Frederick County, Maryland

2016 Community Health Needs Assessment

This document was prepared for the Frederick Memorial Hospital and Frederick County Health Department by Cherise B. Harrington, PhD, MPH and project team at The George Washington University Milken Institute School of Public Health, Department of Prevention and Community Health.

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EXECUTIVE SUMMARY

Background: The Frederick Memorial Hospital and Frederick County Health Department partnered with The George Washington University Milken Institute School of Public Health to sponsor the 2015 Community Health Needs Assessment in Frederick County, Maryland. The goal of this needs assessment was to survey a representative sample of county residents to identify the health priorities and the barriers they encounter in accessing health care in the Frederick County.

Objectives: The overall objective of the needs assessment is to assess the health and health needs of Frederick County residents.

Methods: A mixed method approach was used to assess the needs and identify resources and barriers to maintaining health and accessing health care in Frederick County. The Frederick Memorial Hospital, Frederick County Health Department, and The George Washington University, Milken Institute School of Public Health Project Team collaborated on an approach to conduct the community health needs assessment that consisted of three activities: recruiting and conducting up to 500 in-person needs assessment surveys (Part 1); recruiting and conducting six focus groups with specific community groups to gather more in-depth information regarding health needs and barriers (Part 2), and third, recruiting and conducting 20 structured interviews with key community members, leaders and providers (Part 3). Eligibility criteria included being English-speaking or Spanish-speaking (for Parts 1 and 2 only), a county resident of at least 12 months to 18 months depending on data procurement activity, and over the age of 18.

Part 1: The in-person needs assessment instrument was an 83-question questionnaire that took 15-25 minutes to complete. This questionnaire assessed demographics, social and environmental factors, health behavior, health status, health priorities, and perceived barriers to care. The instrument also asked about perceptions of community level health priorities and barriers. Participants were compensated with a $10 gift card upon completion of the survey.

Part 2: County residents participated in six 60-90 minute focus groups ranging in size from 5 to 15 participants. Focus group participants were asked about their health needs, accessibility of health services in the county, and barriers to care. Participants were compensated with a $15 gift card upon completion of focus group.

Part 3: Twenty residents who were involved in the community either through employment, residence, or an organizational affiliation were asked to complete a 30-60 minute structured interview conducted via telephone. Interviewees were asked about their organization's participation in health care, perceived health priorities and barriers, and were asked open-ended questions that solicited suggestions and ideas on what and how to improve health in the county. Participants were compensated with a $20 gift card upon completion of interview.

Results: Part 1 Surveys: N=483 Frederick County residents participated in the needs assessment. At least 24 cities/towns/municipalities in the county were represented, however the majority of participants resided in Frederick (70%). The average age was 48.9 with a range of responses from 18-88. The sample was 68% White, 21% Black or African American, and 13% reported being Hispanic or Latino. In general the sample was mostly female (68.1%), married (52.6%), had completed at least some college (72%), and employed (62%). With regard to income, we see wide distribution with 18.1% of the sample reporting annual incomes of less than $14,999, 10% between $15,000 and $24,999, 30% between $25,000 and $74,999, and 35% reporting $75,000 or greater.

Eighty-four percent (84.7%) of the sample reported good or better health. However, 6.4% reported at least one physical limitation. Most were overweight or obese (52.1%). Physical activity (67.5%), weight (65%), and eating properly (61.9%) were the highest rated health priorities. The biggest barriers to care were cost of prescriptions (32.7%), cost/paying co-pays or fees upfront (28.2%), insurance problems (28%), awareness of available services (25.2%), locating the right doctor for health issue (24.9%), not enough time with my doctor (24.5%), employment challenges (22.2%),

doctors who do not accept my health insurance (21.1%), and respectful treatment by physician and staff (18.7%).

Secondary data analyses were conducted to investigate income, race, ethnicity, education, and insurance status based differences. In general, the uninsured, less educated, and minority residents reported more health needs, health care needs, more barriers to care, and more access to care issues.

Part 2 Focus groups: Although every focus group had individuals who thoroughly enjoyed living in Frederick County and felt that their health needs were being met, there were some common barriers to healthcare and health priorities that were noted. The majority of the groups cited strengthening mental healthcare and addressing the shortage of primary care providers within the county as health priorities. All focus groups discussed transportation as a barrier to care. Some have noticed a shortage of primary care providers and a limited number of specialists practicing in the county. The status of a Frederick County resident's health insurance also affects whether or not care is received. Other issues reported by focus groups participants included lack of communication and awareness of the health services and resources available within Frederick County. They felt that better communication and coordination among organizations would help to facilitate improved healthcare for all.

Part 3 Structured Interviews: Participants, informed from their position in the community, agreed that Frederick County is not worse off than other counties in regards to health. However, participants had varying views on what health services should be improved and what barriers Frederick County residents face in accessing health care and services. Three of the top health priorities included weight management, eating properly, and cancer prevention. The top three barriers to health care access were transportation, lack of awareness of services, and issues relating to costs, insurance and payment. Seventy percent of interviewees chose to disagree or remain neutral when asked if available services adequately met the needs of the community.

The report also includes comparisons with 1) current census data and 2) the previous needs assessment. This report compares the current needs assessment demographic data with census data to assess our sampling and recruitment strategies. In general, compared to the most recent census data our sample was more educated 48.87% vs. 38.2% County and vs. 36.8% statewide with a bachelor’s degree or higher. The recruiting and sampling approach taken allowed us reach a larger number of Black/African Americans (21.7% vs. 9.4%) and Hispanic/Latinos (13.1% vs. 8.4% county and 9.3% statewide) residents and a lower number of White residents (68.3% vs. 82.8%) compared to the most recent county and statewide census data. We collected income data differently, using categories vs. a specific dollar amount. The data show that the sample was grouped in thirds with regard to income. Twenty-eight percent of the sample reported annual incomes of less than $24,999; 30% reported incomes between $25,000 and $74,999 and 35% report incomes of $75,000 or greater; compared to a median income of $84,570 according to the census**.**

This report also includes a comparison to the previous (2013) county needs assessment and 2015 interim report in order to assess changes, gaps, and compare sample characteristics. There were some notable differences: the percent obese increased from 24.8% in 2013 to 33.3%. In reported chronic illnesses percentages reporting overweight/obesity was 52.1% in this sample compared to 60.9% in the 2015 Interim Report; High cholesterol was lower at 22.2% vs. 36.8%; high blood pressure was higher 30% vs. 27.9% vs. 0.2%; diabetes was higher at 13.9% vs. 9.3% vs. 0.3%; asthma was significantly higher at 12.4% vs. .049%; and arthritis was lower at 17.4% vs. 22.7. Cigarette smoking was lower in the current sample, with 14.6% vs. 19.8%. Cancer screenings were similar: mammograms with 87.2% vs. 80.0%, pap smears with 80% vs. 83.3%; and colonoscopy with 58.8% vs. 70%. Health insurance was also compared. Health care coverage was slightly lower at 87.4% vs. 92% and lack of insurance coverage at 12.6% vs. 9%.

Conclusions: Overall the recruitment approach was successful in obtaining a representative sample. Future efforts should consider ways to increase yield among home bound residents, the deaf and hard of hearing residents, Asians, Pacific Islanders, and American Indians. The data also highlighted gaps in care and identified areas to potentially leverage into additional programs, services, and interventions.

Recommendations: It would be the recommendation of the project team that additional secondary analyses be conducted on the data to explore patterns not immediately evident in the descriptive analyses and initial bivariate comparison data. More statistically sophisticate modeling may be useful for planning purposes. Additionally, future efforts should seek to incorporate more of the community in the planning and execution of the needs assessment. These efforts could include convening an advisory board that includes community members and also hiring community members to assist in data collection. In order to further explore some of the priority concerns and problems of county residents and solutions, regular focus groups made up of county residents could be instrumental in generating ideas, and identifying resources and potential barriers prior to implementation of proposed programs or services.

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INTRODUCTION

Frederick County is one of 23 counties in the state of Maryland[1] and has an estimated population of over 243 thousand[2]; 76.5% Non-Hispanic White; 8.6% Non-Hispanic African American; 8.0% Hispanic; and 4.4% Asian.[3]

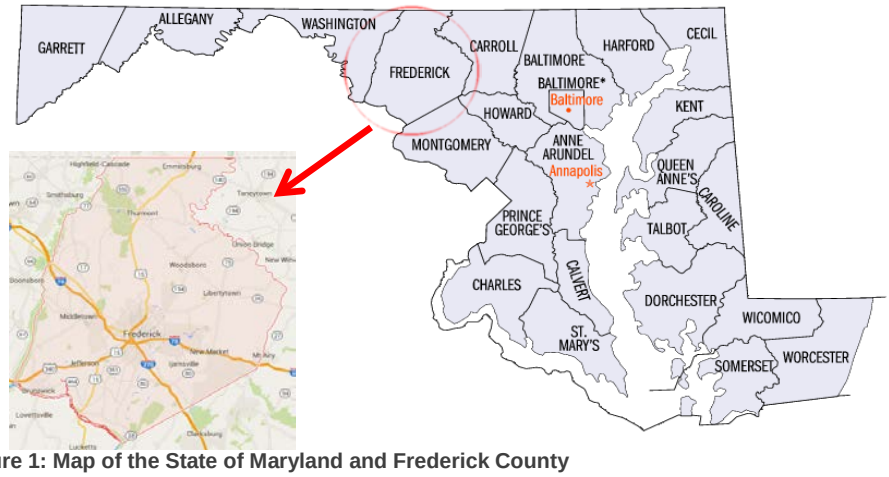

Figure 1: Map of the State of Maryland and Frederick County
United States Census Bureau. (2013). *Maryland County Selection Map.* Retrieved from State & QuickFacts: http://quickfacts.census.gov/qfd/maps/maryland_maps.html
Google Maps. (2016). Retrieved from Google Maps: https://www.google.com/maps/place/Frederick+County,+MD/

Frederick County, located within 1.5 hours of driving from Washington, D.C, Baltimore, MD, and Gettysburg, Pennsylvania, is distinguished as where the "hip meets the historic".[4] It is where "museums meet martini bars, scenic landscapes provide thrill seekers with adventure, and cutting edge cuisine is served up in Civil War-era buildings alongside unique specialty shops, galleries, museums, and theaters".[4]

In recent years, Frederick County has seen relatively favorable health and socioeconomic trends in comparison to the rest of the state of Maryland. For instance, the County has better rates of premature death (4,995 years of potential life lost before the age 75 per 100,000 population as compared to 6,459 in Maryland), uninsured (9% compared to 12% in Maryland), and high school graduation (93% compared 83% in Maryland). On the other hand, Frederick County ranks second to lowest in comparison to the other counties in Maryland for physical environment. Seventy-seven percent of Frederick commuters drive to work compared to 73% in Maryland, and 48% of those who drive alone have a commute longer than 30 minutes compared to 47% in Maryland. Additionally, Frederick County has seen an increase in drinking water violations (22%) as compared to Maryland (16%).[5]

In terms of clinical care, Frederick County has 1,699 patients for every 1 primary care physician (PCP), while Maryland has a 1,131:1 patient to PCP ratio. Although adult obesity is lower in Frederick County as compared to Maryland, (27% with BMI> 30 compared to 28%) this rate has been worsening over the past several years.[5] In hopes of keeping the favorable health trends and further exposing concerning trends, Frederick Memorial Hospital and the Frederick County Health Department sought to identify the limitations, barriers, and gaps in the community by partnering with The George Washington University, Milken Institute School of Public Health to sponsor a Community Health Needs Assessment with the overall objective to improve the health outcomes of the Frederick County community.

BACKGROUND

Community Definition and Characterization of Frederick County, Maryland

Frederick County is located in Maryland, bordered to the north by Pennsylvania and to the south by Virginia. It is one of 24 Maryland counties/jurisdictions. The county is part of the Washington-Arlington-Alexandria, DC-VA-MD-WV Metropolitan Statistical Area, as designated by the United States Office of Management and Budget (OMB).[6] The county includes twelve incorporated municipalities and cities: Brunswick, Burkittsville, Emmitsburg, Frederick, Middletown, Mt. Airy, Myersville, New Market, Rosemont, Thurmont, Walkersville, and Woodsboro.[7] Frederick County has one hospital and numerous clinics where health care services for a variety of health needs can be received.[8]

Racially, the county is 82.8% White, 9.4 Black, 4.5% Asian, 8.4% Hispanic or Latino, and American Indian and Alaska Native account for less than 1.0%; 2.7% of the population identified as Two or More Races.[3] The median age of the county is 38.9 years old. The population aged 5 or younger is 6.1%, 75.5% are over 18 years old, and 12.0% are aged 65 and older.[9] In Frederick County, the median household income is $84,480 with 6.5% of the population living in poverty.[10, 11] The population of children under the age of 18 living in single-parent homes is at 22.4%. Seven point seven percent of families in Frederick County have a single head of household.[12] Of individuals aged 16 years and over in the civilian labor force, 68.4% were employed in 2010 and 3.5% were unemployed.[10] However, since 2010, the unemployment rate has risen to 5.7%.[5] According to the 2014 Frederick Community Health Assessment, individuals identified as White has a higher percentage of persons employed compared to individuals who identified as Black or African American.[13]

When compared to counties touching its borders, Frederick County ranks 3rd in terms of health outcomes and reference to health factors; comparable to its surrounding counties, if not better. The county shares borders with Montgomery County and Howard County to the south, ranked number 1 and number 2 respectively in overall health outcomes. To the west, it is bordered by Carroll County, which is ranked 4th in overall health outcomes, and to the east, Washington County, which is ranked 13th.[14]

Health Needs Assessments

Needs assessments are used to identify barriers and limitations in a selected population.[15] Sponsored by an individual or organization, such as a hospital or health department,[16] they can be used to (1) identify gaps between current health status and those desired, and to (2) categorize such gaps via level of importance and source of influence (environmental, behavior, genetic, or

healthcare).[16] Once categorized, the timeframe of the desired outcome is established i.e. short-term, intermediate-term, or long-term, based on the resources and objectives outlined by the sponsor.[16]

Needs assessments can support why a state, organization, etc. has chosen to prioritize and allocate their funds towards specific areas/issues. A successful needs assessment requires a project manager to plan and manage the project.[17] The need assessment committee, which includes the project manager and sponsor(s), should work out a reporting schedule and share progress and relevant information regarding the needs assessment to ensure that the findings and recommendations of the need assessment are implemented in a timely manner. The needs assessment committee should identify need indicators and data sources.[18] These indicators can validate if a specific concern exists. Ideally, needs assessments should take place in cycles to continuously improve the conditions of the selected population. There are no absolute and defined approaches to a needs assessment.[18] The methods are determined by funding from the sponsor, the specific needs of the targeted population etc.

Health needs assessments have many benefits, including the development of a roadmap of how to reach a specific health or/and behavior objective and defining indicators that will capture the completion of such objectives.[16] Other benefits include a snapshot of the health needs of an entire community, generating stakeholder understanding, and support of needed programs and increased visibility of the sponsor in the community.[19]

Limitations of a needs assessment are introduced once the method of research is chosen; i.e. quantitative versus qualitative. Quantitative research methods of assessment are objective, generalizable and are used to test concepts, constructs, and hypothesis of a theory[20]; examples include surveys, structured interviews, and observations.[20, 21] Qualitative research methods are subjective, less generalizable, and are used to formulate a prediction[20] examples include focus groups, in-depth interviews and brainstorming.[20, 21]

Design Rationalization: Using in-person community-based sampling

In community-based approaches, it is beneficial to use designs that are sensitive to sociocultural backgrounds of the community. Community-based recruiting is most successful when there is a partnership between the researchers and local, community-based organizations. When organizational partners introduce the research and its potential benefits to people in their own organization, such as churches or hospitals, recruitment is much more successful than researchers trying to build trust and create interest among community members without the buy-in from and engagement with local organizations.[22] In-person recruitment allows for creating and building trusting relationships with community partners and engagers. This strategy allowed us to achieve a much higher participation rate than trying to recruit remotely because the participating community

members knew the staff and trusted the community-based organization we were engaging with. Overall, research supports telephone recruitment and in person meetings with potential participants helps to increase rates of recruitment.[23]

Additionally, in-person community based participatory methods have the potential to establish meaningful relationships and give voice to those already working in local communities towards achieving positive health outcomes. Engaging community members who are already working in local communities not only builds trust but empowers members of the community to serve as active leaders with a voice.[24] Both sampling approaches were used in this assessment.

Rationale

In summary, aging, rural, low income populations, and minorities are burdened by significant health disparities characterized by increased health risks, less engagement in preventive behaviors, increased incidence (for most diseases), and increased mortality rates. The high individual and public health burden of disease and health disparities make prevention efforts of critical importance. The best approach to plan and implement primary and/or secondary prevention programs is through a thorough understanding of the needs in a community. As previously stated, the purpose of a needs assessment is to engage key stakeholders in a process of gathering and synthesizing data that includes demographics of a populations, resources, needs, barriers, health risk factors, and disease incidence and prevalence. The current report summarizes the process, methodology, and data from a community health needs assessment conducted in Frederick County, Maryland during Fall/Winter 2015.

METHODOLOGY

Overview

The Frederick Memorial Hospital with the support of the Frederick County Health Department and The George Washington University, Milken Institute School of Public Health identified a mixed method approach in order to conduct the needs assessment. The research design consisted of in-person surveys, phone-based structured interviews, and focus groups. In order to be eligible to participate persons had to be English- or Spanish-speaking, have resided in Frederick County for at least two years, and be aged 18 and older. A primary sample of 500 was chosen to represent the greater population using a self-report questionnaire (Part 1: survey). In addition, six focus groups were conducted on select target groups (Part 2). Lastly, structured interviews (Part 3) also were conducted with individuals who not only met the overall eligibility criteria but also were involved in the community either through employment, residence, or organizational affiliation. A sample of 20 was chosen to represent the greater population using the mode of a structured interview.

We selected this multi-method approach to allow for a triangulation of data that benefits from the combined strengths of these data collection methods, while also having the ability to offset the individual limitations within any one of the methods. As with any questionnaire or survey involving human research subjects, there are risks and benefits associated. The major benefits of questionnaires are that they can collect information from large groups,[25] they can be easily administered, their results can be quickly analyzed through the use of statistical software, and they are inexpensive to administer.[26] The risks associated with questionnaires are that they can be timely in their completion, there are limitations in measuring the truthfulness of respondents' answers,[26] and they may miss an unlisted barrier in the community as they do not readily allow for open ended responses.[27] The limitations of the questionnaires were considered before, during, and after the administration of the survey and were also accounted for during analysis of the survey results.

As mentioned, in addition to the survey, focus groups were used to further capture data. The use of focus groups and interviews are two such inexpensive tools that would help in capturing large amount of quality data with in social context. The main purpose of focus groups is to understand the factors that influence the feelings, attitudes and behaviors of an individual and a group.[28] Focus groups help in understanding the underlying assumptions behind an individual's opinion towards a topic and allows the researcher to observe and record the verbal as well as the nonverbal opinions of the members of a group.[29, 30] The primary advantage of using focus groups is the natural setting of the group environment. This allows the individuals to have a conversation in their own language and style, with fewer constraints. Other benefits are that it allows for the collection of large amounts of

data from several people at the same time. The dynamics of a group help in understanding the consensus or diversity within a group. Additionally, focus groups are the best way to obtain information from individuals who have difficulty in reading and writing.[28, 30-33] However, despite the benefits, focus group interviews can prove challenging. Time might be a constraint during prolonged discussion among a group, which consequently would limit the questions. Recruiting members for a focus group could be a major problem especially when recruiting from conservative or minority group.[30, 31] Another problem could be attrition and absenteeism.[30, 31] Many times, there is a possibility that the participants do not turn up due to various reasons. Conflicts and confidentiality over opinions might be challenging for the facilitator.[28] Focus group interviews with respect to needs assessment aids in gathering information and opinions among professional and potential groups regarding an issue in focus. These discussion groups could help in generating information regarding the peoples' experiences of health services and diseases/illnesses.[30, 34, 35] It also helps in obtaining information on lifestyles, health behaviors, available health services, barriers to use the services, etc., within a social context.[30, 36-40] In addition, it allows for a better understanding of attitudes, behaviors, and knowledge.[30, 41, 42]

Structured interviews, which are individual interviews conducted on, in this case, a pre-determined, specific population. Structured interviews ensure that each individual has an equal opportunity to provide information and are evaluated in an accurate and consistent manner.[17] This inexpensive assessment method was designed and used to understand the knowledge/understanding about the health needs of Frederick County residents from various professionals and their opinions on how health can be improved for Frederick County residents. All participants were asked the same preset questions in the same order. This method is not as strongly biased when the general participant pool has a mixed literacy skill.[43] It is more personal, but more formal than a normal conversation. The interviewer is able to ask in-depth questions that lead to a deeper understanding and gain an insider's perspective. For this needs assessment, the structured interviews were conducted over the phone by research assistants. The disadvantages are the time and effort to schedule the interview, knowledge and security of the interviewees' private information and the interviewer is not privy to the interviewee's nonverbal cues (due to the phone-based approach) and cannot convey questions based on the cues.[44] However, strength of this approach is that the interviewer can enter the answers directly into the database and ask for clarifications and explanations.

Part 1 – Community Health Needs Assessment Survey

A sample population of N = 483 was randomly recruited from various sites to complete the survey. Recruitment efforts took place in the following Frederick County locations: Frederick Memorial Hospital, Safeway Grocery Store (927 West 7th St.), Westview Promenade, Walmart (7400

Guilford Dr.), Downtown Frederick, YMCA of Frederick, Brunswick, Centro Hispano, Lutheran Evangelical Church, Urbana Senior Center, a breast cancer survivor event hosted by Faith STRIDERS held at Dutch's Daughter Restaurant, and at the Wholeness 365 Ministries Fitness Expo, and at the Religious Coalition for Emergency Human Needs (See Table 1).

Procedures

The owners and managers of each location were contacted in advance by a George Washington University (GWU) Milken Institute School of Public Health project team member (graduate student) for their permission to conduct the health needs assessment in or on the property of the establishment. This included establishing a time, date, and location convenient for all stakeholders involved. The project sought out times, dates, and locations that attracted high levels of resident activity at any one location in order to collect a high yield of surveys.

At these locations, the project team set up between two to three tables and four to six chairs to allow participants to sit down while they completed the survey. Project team members wore bright orange sweaters to attract the attention of the community, and taped to one of the tables was a sign that read “Are You 18 or Older and a Frederick County Resident? Get a $10 Gift Card, Ask Me How." These methods were utilized in an effort to engage as many community members as possible to participate in the survey.

Each participant was solicited by the team to participate in the survey via an introductory greeting. Candidates were (1) informed about the needs assessment’s purpose, sponsors, risks and benefits, (2) asked about their residency and age, and (3) and if they were English speaking, 18 years of age, and a resident of Frederick County for at least two years. If found to have met the outlined criteria, they were asked to participate in the survey and informed of the $10 gift card incentive that they would receive upon completion of the questionnaire. If a candidate verbally agreed to participate, they were provided an institutional review board (IRB) approved informed consent form to review and sign before the start of their self-administered survey. The IRB Informed Consent is a summary of the needs assessment including its’ purpose, procedure, risks and confidentiality, benefits, costs ($10 gift card incentive), along with an IRB assigned number, and information on how to reach the principal investigator for questions, concerns, complaints, or other inquires. Participants were also offered a copy of the IRB informed consent for their records.

Prior to the start of the self-administered survey, participants were provided a pen and clipboard, and were encouraged to ask project team members questions throughout the survey, should they need clarification about a survey question.

If a candidate chose not to participate in the survey, either before or after their review of the IRB informed consent form, they were given the location and timeframe for future needs assessments, should they change their decision.

If a candidate was found ineligible to participate in the needs assessment they were then given the option of sharing their contact information so that they could be notified of future studies that they could participate in if they qualified at that time.

Completed surveys and signed IRB consent forms were kept separately in labeled envelopes, which were securely kept to protect the identity of the participants.

Upon completion of the survey, participants' names were written on a log sheet to keep track of the participants' receipt of the $10 gift card incentive.

Measure (Community Health Needs Assessment Survey)

The self-administered survey was comprised of 83 questions, and included the following sections: Demographics, Environmental Influencers, Health Behavior, Health Status, Health Priorities, and Perceived Barriers to Care. The survey used a number questions from the Behavior and Risk Factor Surveillance System (BRFSS) where applicable. Overall, each section attempted to create a personal profile of each participant. The personal profile assisted with qualitatively assessing their needs, the needs of Frederick County, and their perceived outlook on the needs of the County community as a whole. Collecting information on the participant's needs sought to uncover barriers and limitations, as well as strengths and opportunities within existing healthcare initiatives. Collecting information on the needs of the participant's family's assisted with retrieving data on people that we have not directly reached through survey solicitation. In addition, understanding the needs of the participants' family's also provided insight to any burdens that the participant may be facing as a caregiver. How an individual views their community is equally important as it supports validity that what each participant has reported on themselves and their family, is not only true at the individual level, but perhaps on the community level as well.

Demographics

The Demographic section of the survey included questions that were specific to the individual survey participant and included variables such as age, gender, ethnicity, marital status, sexual orientation, education level, employment level, employment status and type, income source and amount, health insurance status and type, home ownership, number in household younger than and older than age 18 weight and height, city name where they currently reside, and geographical prevalence (months and years in Frederick County). The variables used in this section were a mixture of multiple choice and written responses (age, geographical prevalence, city name, health

insurance type, and age). This section facilitated the identification of those in the community that are in most need of assistance and those in the community that are thriving.

Social and Environmental Factors

A person's experience in specific situations or events can influence their health behavior. The specific variables used to identify environmental influencers include experience based on race and/or ethnicity, areas of stress or worry regarding health and or social environmental factors, experience or knowledge concerning health-focused organizations, and experience or needs regarding previous arrest records or incarceration. This section used a combination of multiple choice and open ended questions. Other examples of environmental influence include supports from family and friends (social), health care providers and health department (professional), and marketing initiatives such as magazines, television, the internet, or videos (media).These variables are also a major contributor to health behavior.

Health Behavior

A person's health behaviors can contribute to their overall health status or other defined conditions or diseases. Examples of health behavior include but are not limited to smoking habits, receipt of vaccinations or standard health tests and exams, frequency of exercise and consumption of fruits and vegetables, and the use of health services (frequency and type). These variables will assist to predict if and how certain health behaviors have influence the health status of the members of the community.

Health Status

Participants in the self-administered survey were asked about the health status of themselves and their family, and their perceived outlook of the health status of the community. The following variables were used to assess the participant's health status; diagnosis of disease and/or disorder, disability (physical and mental), mood, and injuries. Similarly, diagnosis and disability were variables associated with the collection of family health; other variables included the status of health insurance and frequency of use of healthcare programs in Frederick County. Questions concerning the health status of the community were congruent with that of the family. Overall, these variables identify the health issues that are relevant in the community.

Health Priorities

The priorities of the survey participants are critical in analysis. Although the collection of demographics, environmental influencers, various health behaviors and status tell the story of the health issues for that particular, this information does not explicitly indicate whether those individually reported issues are important to community as a whole. With any community-based intervention, regardless of how well planned and implemented, if it is not accepted by the target

population on a large scale, it has potential to fail. By gathering data on the health priority of the individual participants and the community as a whole, we can try to communicate and convey which priorities exist and why. Examples of variables used to identify health priorities include chronic illness treatment, exercising, and eating properly.

Language and Health Literacy

Participants also were asked questions designed to help ascertain their reading ability, preferred language, and language and literacy issues relevant to provider-patient interactions. These questions are helpful in understand the role of language and literacy on health, health care, and barriers to care.

Perceived Barriers to Care for Self, Family, and Community

Survey participants were asked what they perceived as barriers to themselves and in the community. The variables used to measure the barriers were transportation, medical/physician experience, and financial means. Identifying and understanding perceived barriers will help to align the overall needs of the individuals and community as well as support the identified health priorities.

Data Analysis

The statistical software used to analyze the data was SPSS version 23. Descriptive analyses and bivariate analyses (chi squared tests) were conducted to analyze the data. For the comparison analyses statistical significance is observed when the P value or calculated probability (i.e., probability of the occurrence of an event) is less than or equal to .05 (i.e., $p \leq .05$). Values of $p <$ .001, .01, .05 are reflected when appropriate to denote strength of the association.

Part 2 – Focus Groups

Part 2 of the project consisted of focus groups. Six focus groups were conducted with a total sample of n = 49. Certain populations were targeted and recruited for focus groups based on 1) limited access to a particular population during the survey recruitment or 2) a specialized group that was believed to possess key information and experiences. Groups were targeted and recruited by liaisons at the following organizations: Urbana Senior Center, Frederick Memorial Hospital, Centro Hispano, Frederick Primary Care Associates, and The Religious Coalition for Emergency Human Needs.

Procedures

The GWU project coordinator, with guidance from staff at Frederick Memorial Hospital was responsible for contacting various organizations to host focus groups with targeted groups. A total of six focus groups were conducted, each lasting 60-120 minutes. Populations that were targeted for

focus group were senior citizens, providers, community health educators, Spanish speaking residents and the homeless. Participants were provided with a $15 gift card for their input.

Measure (Focus group Discussion Guide)

The focus group guide was comprised of 7 to 12 questions, and included the following sections: advantages and disadvantages of living in Frederick County, satisfaction with providers and available services in the county, areas for improvement, barriers to care, and family health needs. The focus groups with providers asked few additional questions that focused on the needs of the care community that they serve and the availability and accessibility of the needed services. Collecting information on the participant's needs sought to uncover barriers and limitations, as well as strengths and opportunities within existing healthcare initiatives. Collecting information on the needs of the participant's family's assisted with retrieving data on people that we have not directly reached through survey solicitation. In addition, understanding the needs of the participants' family's also provided insight to any burdens that the participant may be facing as a caregiver. How an individual views their community is equally important as it supports validity that what each participant has reported on themselves and their family, is not only true at the individual level, but perhaps on the community level as well.

Following the focus group discussion, focus group participants were also asked to complete a short five-question demographic questionnaire and a short-evaluation of the focus group process.

Data Analysis

The statistical software used to analyze the data was NVivo. Qualitative analyses were conducted to identify themes and group responses.

Part 3 - Interviewer Structured Questionnaire

Structured interviews were conducted on 20 individuals. These individuals were selected based on their involvement in the community as providers, community members, or leaders. Participants were affiliated with a number of county organizations, faith-based organizations, government positions, and health care professionals.

Procedures

Participants were contacted via email by the GWU project coordinator and scheduled with a research assistant for a phone interview lasting 30 to 60 minutes. Upon scheduling confirmation, participants were provided with an IRB approved consent form and interview questions to prepare answers for a smoother interview experience. Informed consent was given verbally by the participant

at the beginning of the structured phone interview. Participants were also made of aware of the research assistant's name. Participants were given a $20 gift card for their input.

Advantages and Disadvantages of Interviewer Structured Questionnaire

Advantages of interviewer structured questionnaire include increased response rate to questions, clarity in questions asked so that the intended response is received, standardization due to the fact that all participants were asked the questions in the same manner therefore increasing standardization.[45]

Limitations of interviewer structured questionnaires include interviewer bias, reduced honesty from participants potentially due to the fact that information will be shared verbally with another person rather than anonymously in a self-administered survey, and duration. While these were structured interviews, flexibility did exist that allowed participants to deviate from the survey to hold a conversation with the interviewer.

Measure (Structured Interview)

The structured interview was comprised of 39 questions, and included the following sections: Demographics, Environmental Influencers, Health Behavior, Health Status, Health Priorities, and Perceived Barriers to Care. A majority of the survey used questions from the Behavior and Risk Factor Surveillance System (BRFSS) where applicable. Overall, each section attempted to create a personal profile of each participant. The personal profile assisted with qualitatively assessing the needs of Frederick County, and their perceived outlook on the needs of the County community as a whole. Collecting information on the perceived participants needs sought to uncover barriers and limitations, as well as strengths and opportunities within existing healthcare initiatives. Collecting information on the needs of the community that the organization was directly associated with, assisted in retrieving data on people that we have not directly reached through survey solicitation. As a member of organizations that are involved in the health of the community it is important to understand how these individuals view their community in comparison to other individuals who took the self-administered surveys.

Organization and its Role in Community Health

This section of the survey included questions that were specific to the individual representing an organization and included variables such as name of the organization, position held, number of years/months spent in the position and the number of work hours spent per week. It also includes a question to identify whether or not the interviewee resides in Frederick County. This section also included variables to identify the various health services/ programs offered by the organization and their success and failures rates with inclusion of reasons. It also included variables around the kind of population they served (percent of specific racial groups, females, males, single residents,

married residents, younger residents, families, seniors or LGBTQ residents). The variables used in this section were a mixture of multiple choice and written responses (information about organization, health priorities, residence, and focus of the health programs offered and the level of participation of the community). This section facilitated the identification of organizations that are involved in health related services, health priorities of the community, the programs that are available and those that are needed in the community.

Position in Organization

Structured interviews focused on understanding the health needs of Frederick County from the perspectives of the members of various health organizations in the County. It is therefore imperative to understand their position in the community, their priorities and the challenges they face. To identify similar information, this section included variables around the time spent personally doing the programs, the interviewee's ability to negotiate and collaborate with other organizations and local leaders like themselves. The section also included variables to identify areas of developments, health priorities to improve the residents' health, specific challenges they face and how they overcome them.

Health Promotion

Any organization and its services can best reach the community they serve through a well-planned health promotion. In order to identify this information, variables to identify the organization's modes of promotion were used. Examples of the ways to share health information and to promote the services offered by the organization were social media, faith-based efforts, health-related banners, videos, workshops, health magazines, printed material, etc. A person's exposure to various health services and programs can influence their health behavior. Therefore these variables are also a major contributor to health behavior.

Perceived Health Behavior

A person's health behaviors can contribute to their overall health status or other defined conditions or diseases. Examples of health behavior include the participation level of the community members in any health related programs or services offered by the organization/ community. These variables will assist to predict if and how certain health behaviors have influence the health status of the members of the community.

Perceived Health Status

Participants in the structured interview were asked about their perceived outlook of the health status of the community. The interviewees were asked to rate the health of Frederick County residents, health services availability, health programs offered by the hospital and the health department, adequate access to health services and whether Frederick County residents had unique

health problems. Similarly, variables were used to identify the health status of the immediate community that the community serves.

Perceived Health Priorities of the Community

The priorities of the survey participants are critical in analysis. Although the information about the organization and the services they offer, environmental influencers, various health behaviors and status tell the story of the health issues for that particular organization, this information does not explicitly indicate whether those individually reported issues are important to community as a whole. With any community-based intervention, regardless of how well planned and implemented, if it is not accepted by the target population on a large scale, it has potential to fail. By gathering data on the health priority of the community as a whole, we can try to communicate and convey which priorities exist and why. Examples of variables used to identify health priorities include chronic illness treatment, exercising, eating properly, sexual health and reproductive health, smoking cessation drug abuse, oral health, mental health and asthma/ respiratory problems.

Perceived Barriers of the Community

Survey participants were asked what they perceived as barriers in the community. The variables used to measure the barriers were transportation, medical/physician experience, and financial means. Identifying and understanding the perceived barriers will help to align the overall needs of the individuals and community, as well as support the identified health priorities.

Data Analysis

The statistical software used to analyze the data was SPSS version 23. Descriptive analyses were conducted to analyze the data.

NEEDS ASSESSMENT: SUMMARY OF SURVEY RESULTS

RESULTS

Recruitment

In an effort to select a sample that was representative of the overall Frederick County population, residents were recruited from many different locations around the county. The largest number of surveys came from Frederick city. See Table 13 & 14.

Demographics

After administering the needs assessment surveys, collecting the data and analyzing it, we were able to characterize our sample through demographic data. There were a total of N = 483 individuals who completed the survey in its entirety. See Table 15.

Gender and Sexual Orientation

The majority of responders identified as women (68.1%) while men represented 29.6% and transgendered .4% of the sample. When asked about sexual orientation the majority of respondents reported being heterosexual (87.6%).

Age

The average age for the surveyed residents was 48.59 and the majority of responders were between the ages of 45-54 and 55-64 (36.2%), with the smallest portion of responders being aged 18-24 (7%).

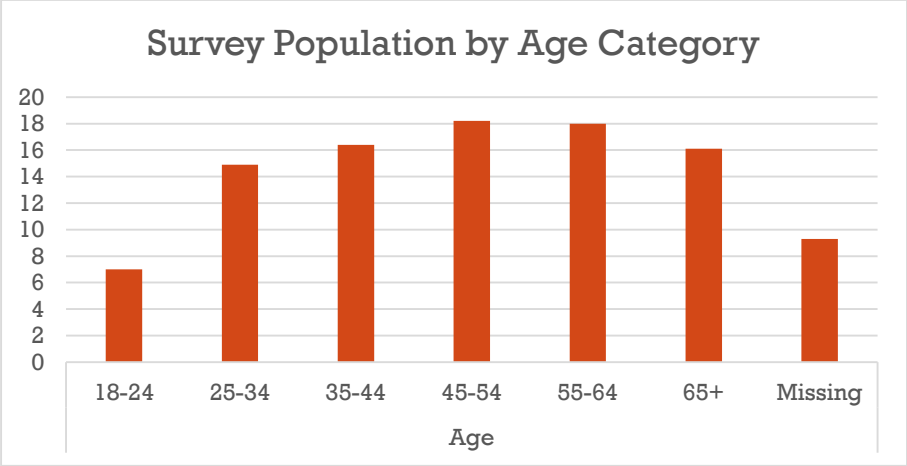

Figure 2: Survey Population by Age Category

Race and Ethnicity

In terms of race and ethnicity, the majority surveyed were White or Caucasian 67.7% while Blacks or African Americans made up 24.8%, Asians 3.3%, and Native Americans/American Indians made up 2.5%, and Native Hawaiian or other Pacific Islanders made up less than 1% (.04%). Almost 13% of respondents reported Hispanic ethnicity.

Education, Employment, and Income

The majority of county residents reported their educational status as having completed at some college (72.1%), 18% earned a high school diploma, while 9% completed some high school or

less. While most of the respondents reported being employed (64.2%) with about 10% reporting self-employment, the unemployed made up 9.3% of survey responders. Further, there were also residents reporting retirement status (18.2%) as well the inability to work (3.9%).

The breakdown of annual household incomes was as follows: 18.1% of the sample reported annual incomes of less than $14,999, with 10% reporting between $15,000 and $24,999. Thirty percent reported incomes between $25,000 and $74,999 and 35% report incomes of $75,000 or greater.

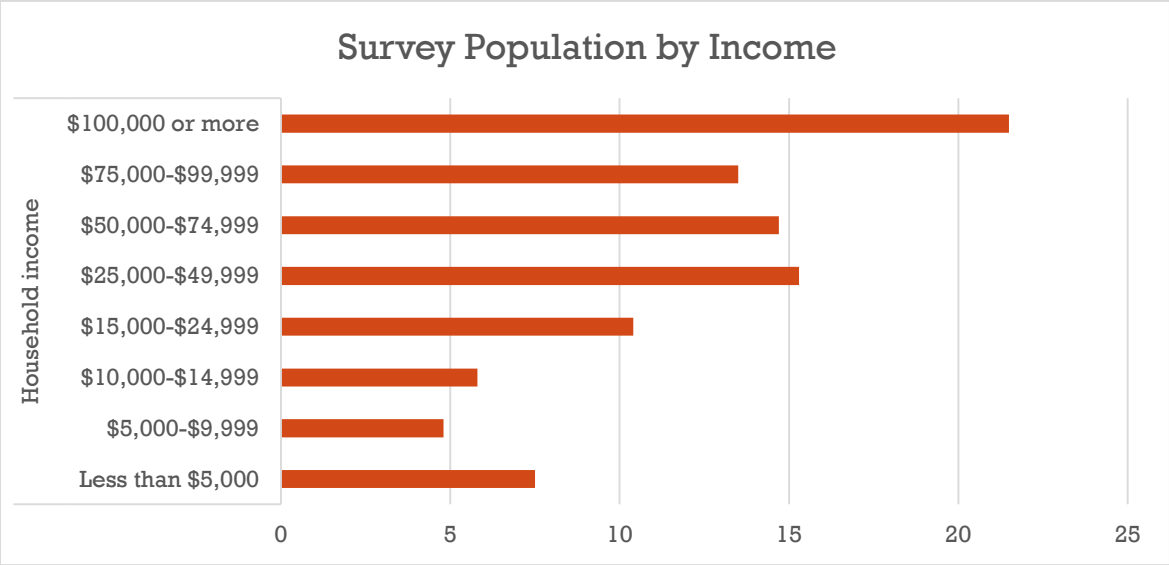

Figure 3: Survey Population by Income

Additionally, the majority of residents owned (52.6%) or rented (28.6%) their homes, while others reported alternative arrangements (14.3%). Additionally, 3.3% of the sample reported homelessness. The majority of the respondents lived in the Frederick (78%). The average Frederick County resident reported having lived in the county for more than eight years (69.4%).

Marital status

When considering marital status the majority of the responders were married (52.8%); followed by 26.3% single, 7% divorced, 5% widowed, and 3.5% separated, and 5.2% cohabitating.

Household Members

Most households had either one or two children (83.6%). There were typically 0-3 adults per household (81.2%).

Language

English was the most common language spoken/used in the home (91.9%) followed by Spanish (13.3%) and American Sign Language (2.3%).

Ratings of General Health

General Health (see complete data in appendices Table 16)

Respondents were asked to rate their general health ranging from poor to excellent, 84.7% of participants rated their health in general as good or better. However, 6.4% reported at least one physical limitation.

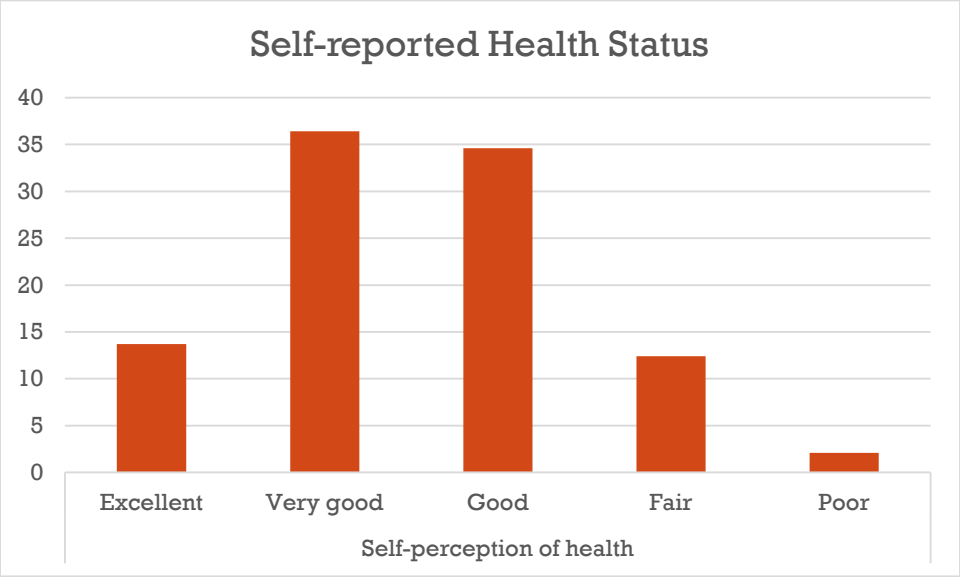

Figure 4: Self-reported Health Status

Health and Risk Behaviors

Health Behaviors (see complete data in appendices, Table 17)

Exercise

Forty-seven percent of respondents report very little to some exercise (less than 10 minutes - 15 minutes per day). Additionally, 25.3% reported exercising for a duration of 30 minutes each time they exercised.

Healthy Eating

Eight-two (82.4%) percent of respondents report consuming less than the recommended amount of servings each day. Only 15.1% report consuming the recommended 5+ servings per day.

Weight

When participants were asked if they believed they were a healthy weight, 45.8% of respondents reported yes, while 48.4% reported that they were not. When Body Mass Index (BMI) was calculated from self-reported height and weight, 18.8% were found to be overweight and 33.3% obese.

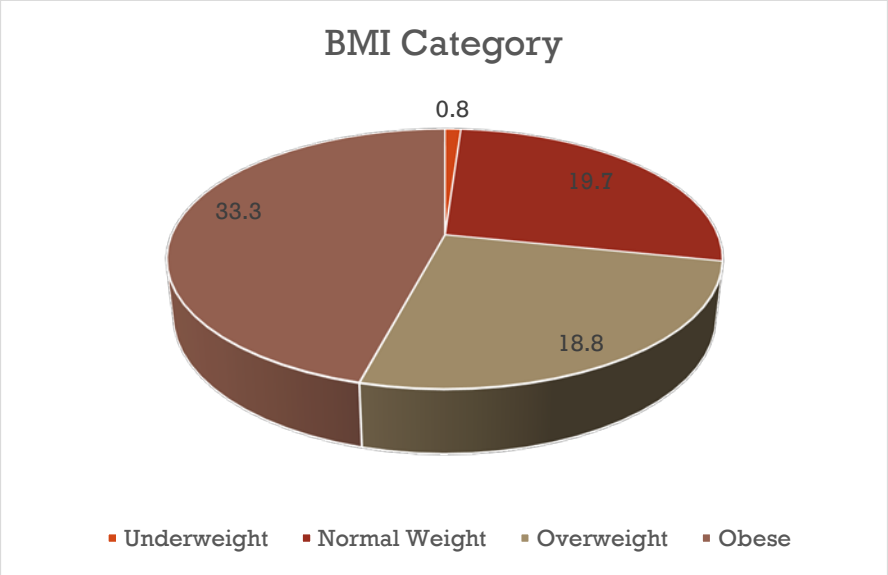

Figure 5: BMI Category

Flu Vaccine

Approximately half (49.3%) of respondents reported getting a flu vaccine in the previous 12 months, with most getting the vaccine from their doctor's office (28%) or the pharmacy (14.3%). Forty-five percent (45.5%) did not receive the flu shot with the most common reason being that "do not need it" (13%).

HIV Testing

Half (50.3%) of participants reported having received an HIV test in the previous five years versus 46.2% who have not.

Preventive Care and Health Care Seeking Behavior

Participants were asked about health care and health care seeking behavior. Eighty-two percent report having a regular physician that they see for check-ups. Additionally, 84% report taking medications as prescribed by their physician.

Cancer Screenings

Participants were asked about cancer screenings. With regards to a colorectal exam and/or a colonoscopy, 43.8% of men (of n = 48 men aged 50 or older who responded to the question) and 58.7% of women (of n = 109 women aged 50 or older who responded to the question) over the age of 50 reported having received those procedures. Women were asked about mammograms and cervical exams: 75.7% of women over the age of 40 report having received a mammogram (of a total of n = 181 women over the age of 40 that responded to this question) and 79.1% of all women reported having had a cervical cancer screening (n = 216 women of the total number of n = 273 women who responded to the question). Men were similarly asked about prostate exams and 52.8% (of the 53 males age 50 or older who responded to this question) reported having received a prostate exam and 38.8% (of the 49 males age 50 or older who responded to this question) report having had a prostate specific antigen test (PSA).

Individual Personal Life and Health Priorities

Characteristics of Family Life (see complete data in appendices)

Participants were asked to rate the frequency of the occurrence of specific worries or concerns using the response options: all the time, most of the time, some of the time, a little of the time, and none of the time. The following percentage of respondents reported the following worriers or concerns occurring “all” or “most the time”; Safety (38.1%), Finances (49%), Housing payment (37.2%), Affording healthy meals (30%), Paying for medication (personal [27.5%] or for a family member [22.4%], Caring for family in an emergency (37.2%), and Job security (29.8%). (See complete data in Appendix 1, Table 18).

Additionally, participants were asked to note the frequency that cost prevented care or concerns with affording care. Nineteen percent (19.9%) of respondents report that cost prevented health care all or most of the time. Similarly, 28% reported that cost prevented receipt of dental services all or most of the time and 20.7% reported that cost affected their ability to obtain medications.

Cost also prevented care for at least one family member with respondents reporting all or most of the time that cost prevented getting medications (17.4%) and dental care (20.5%) for a family member.

Self-report of personal health problems and priorities (see complete data in appendices)

County residents were asked a series of questions to better understand the perception of their health compared to others, the availability of relevant services to fit their needs, and access to those services. These data reflect those that report that they "Strongly Agree" or "Agree" to the following health problems. Twenty-one (21.5%) percent of respondents reported their health was worse than others. Most thought that there were services available to help them address their needs (55.7%) and that the hospital and health department services were relevant to their needs (50.1%). Most also agreed that they had access to needed programs (59% vs. 14.5% who did not agree). Lastly, 17% of respondents report having unique health needs.

Additionally, we asked respondents to rate their personal health priorities. These data reflect those that report that they "Strongly Agree" or "Agree" to the following health priorities. Sixty-seven (67.5%) percent of participants reported that physical activity was a personal health priority. Additionally, most respondents also rated weight (65%), eating properly (61.9%), dental health (49.9%) and cardiovascular health (41.7%) as priorities.

Table 1. Self-reported Health Priority	*%*
Physical activity	67.5
Weight	65
Eating properly	61.9
Oral health	49.9
Cardiovascular disease	41.7
Cancer prevention/treatment	38.3
Mental health	37.2
Diabetes	36.8
Sexual and reproductive health	31.2
Injuries	30.5
Asthma/Respiratory Problems	23.6
Sexually transmitted diseases/infection	19
Alcohol/drug use or abuse	18.4
Smoking cessation	15.6

Physical and Mental Health

Survey participants were also asked to consider the time during the past 30 day that included various physical and mental symptoms. These data reflect those that report that they "Strongly Agree" or "Agree" to the following symptoms: pain which prevents usual activities (12.7%), worried or tense (14.1%), and healthy/energetic (38.3% vs. 31.5%) which reported little to none of the time feeling healthy/energetic).

Table 2. Physical & Mental Health Previous 30 days

DURING THE PAST 30 DAYs, HOW OFTEN DID YOU FEEL…	%
Pain that made it hard for you to do your usual activities	12.7
Sad, blue, or depressed?	10.7
Worried, tense, or anxious?	14.1
Very healthy and full of energy?"	38.3
ABOUT HOW OFTEN DURING THE PAST 30 DAYS DID YOU FEEL …	
Nervous?	11.2
Hopeless?	7.9
Restless or fidget?	8.6
So depressed that nothing could cheer you up?	5.8
Everything was an effort?	10
Worthless?	5.6
A mental health condition or emotional problem that keeps you from work or other usual activities?	7.4

Health Concerns and Priorities (see complete data in appendices)

From a prepopulated list, we asked respondents to acknowledge the health conditions and/or disease that they had been diagnosed with. Thirty percent of the population reported being hypertensive (i.e., having high blood pressure). Additionally, allergies (25.5%), high cholesterol (22.2%) anxiety (19.9%), depression (18.8%) arthritis (17.4%), stress (17.2%), and headaches/migraines (16.4%) and were among the most reported conditions and/or diseases.

Table 3. Percentage of the Sample with a Chronic disease or condition

	#	%
High Blood Pressure	145	30
Allergies	123	25.5
High Cholesterol	107	22.2
Anxiety	96	19.9
Depression	91	18.8
Arthritis	84	17.4
Stress	83	17.2
Headaches/Migraines	79	16.4
Pain	74	15.3
Diabetes (Sugar)	67	13.9
Asthma/Bronchitis/Emphysema	60	12.4
Thyroid Disease	51	10.6
Cancer	48	9.9
Gastrointestinal Disease	36	7.5
Alcoholism/Drinking/Drug Abuse	31	6.4
Heart Disease/Heart Attack/Heart Failure	29	6
Mental Illness	24	5
Autoimmune Disease	19	3.9
Glaucoma	14	2.9
Sexual Problems	14	2.9
Prostate Problems	12	2.5
Epilepsy/Seizures	8	1.7
Stroke	8	1.7
Kidney Disease	6	1.2
Alzheimer's	3	0.6
Vascular Disease	3	0.6
HIV/Aids	1	0.2

Additionally, of these health concerns when asked, 59.2% vs. 26.1% were getting help for their primary health concern. Eighty percent receive their health care in Frederick County and 27.1% have gone to the emergency or urgent care clinic for their primary health concern in the previous 12-months. Lastly, over 80% would receive their care or already do receive their care in Frederick County.

Barriers to Care (see complete data in appendices)

Frederick County residents were asked to acknowledge personal barriers that they experienced in obtaining health care. These data reflect a few of the barriers that participants report that they "Strongly Agree" or "Agree" to experiencing: Cost of prescriptions (32.7%), cost/paying co-pays or fees upfront (28.2%), insurance problems (28%), awareness of available services (25.2%), locating the right doctor for health issue (24.9%), not enough time with my doctor (24.5%), employment challenges (22.2%), doctors who do not accept my health insurance (21.1%), and respectful treatment by physician and staff (18.7%).

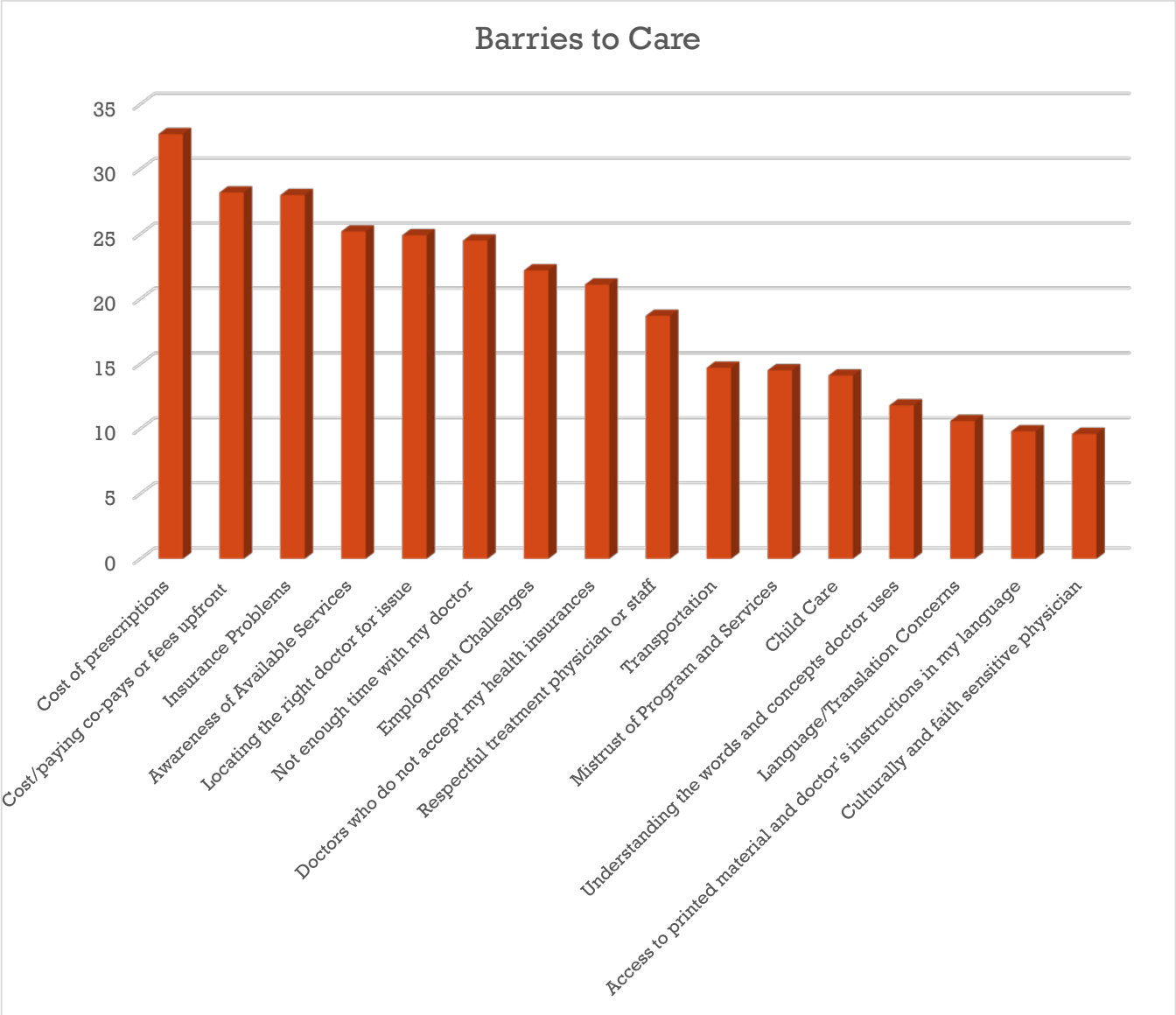

Figure 6: Barriers to Care

Health Information Seeking Sources (see complete data in appendices)

To better understand where residents typically seek and receive health-related information we asked about specific modalities. Most respondents report that they receive information about health related issues from their providers (65.8%), the internet (53.8%), brochures (31.1%), and a friend or family member (22.6%).

Table 4. Health Information Seeking Sources

	#	%
Healthcare provider	318	65.8
Internet	260	53.8
Brochures	150	31.1
Family or Friend	109	22.6
Newspapers	88	18.2
Health Magazines	87	18
Television	58	12
Health Department	51	10.6
Classes	49	10.1
Videos	29	6
Don't know	15	3.1

Program/Service Interest (see complete data in appendices)

To better understand the need and interest for services available in the county, the survey asked a series of questions regarding interest in services of various types and content. The most popular potential services included exercise programs (42.7%), weight loss and healthy eating both at 35%, dental services (30.8%), and personal money management/family budgeting (22.4%).

Table 5. Services that respondent would be interested in if available

	#	%
Exercise Programs	206	42.7
Weight Loss Programs	169	35
Healthy Eating Cooking Classes	169	35
Dental services	149	30.8
Personal Money Management/Family Budgeting	108	22.4
Primary Care Services (Visit with nurse of doctor)	98	20.3
Diabetes (Sugar) Monitoring	75	15.5
Family Counseling	73	15.1
Marriage/Couples Counseling	67	13.9
Mental Health Counseling	66	13.7
Elderly Ageing	64	13.3
Cancer screening and education classes	62	12.8
Family Planning	51	10.6
Chronic Disease Support Groups	31	6.4
Alcoholism/Drug Abuse Counseling	29	6
LGBTQ	7	1.4

Perceptions of the Overall Counties' Health Problems, Priorities, & Barriers

Frederick County Health Problems, Priorities, and Barriers (see appendices)

A series of questions were asked to assess what participants perceived to be the health problems of county residents in general. Respondents were also asked to consider the health of their county and its residents in comparison with others. These data reflect those that report that they "Strongly Agree" or "Agree" to the following health problems. Twelve (12.2%) percent of respondents reported that Frederick County's resident's health was worse than others. Thirty-seven percent thought that there were services available to help Frederick County's residents address their needs, and that the hospital and health department services were relevant to Frederick County's residents' needs (38.9%). Forty-one percent agreed that residents have access to needed programs (vs. 20.7% who did not agree). Lastly, 15.4% of respondents reported that Frederick County's resident's had unique health needs.

County health priorities were also considered. These data reflect those that "Strongly Agree" or "Agree" to the following health priorities. Seventy percent (70.4%) of participants reported that weight was a county-wide health priority. Additionally, physical activity (64.4%), eating properly (60.7%), drug use/abuse (56.6%), cardiovascular disease (53.6%), mental health (53.2%), and diabetes (53%) all were rated as county priorities.

Table 6. Perceptions of Overall County Health Priorities	%
Weight (Overweight/Obesity)	70.4
Physical Activity	64.4
Eating properly	60.7
Drug use/abuse	56.6
Cardiovascular disease/Diabetes	53.6
Mental health	53.2
Diabetes	53
Cancer prevention/treatment	50.9
Smoking Cessation	49
Oral Health	47.6
Sexually transmitted disease	42.2
Asthma/Respiratory Problems	41.7
Injuries	41.3
Sexual and reproductive health	36.5

Perceptions of barriers to obtaining health care were also assessed at the community level. Frederick County residents were asked what barriers exist for most residents in obtaining health care. These data reflect those that report that they "strongly agree" or "agree" to the following: transportation (52.6%), insurance status (59.8%), cost of obtaining prescriptions (56.3%), employment challenges (53.2%), child care (52.1%), awareness of available services (53.9%), mistrust of programs and services (40.8%), language/translation concerns (35.4%), and culturally competent programs (32.7%).

Race and Health Care, Incarceration and Reentry, and Community Engagement

Race and Healthcare (see complete data in appendices)

The survey also assessed racial issues and concerns of Frederick County residents. A series of questions were asked that assessed race and health, perceptions of treatment based on race, representativeness of various ethnicities in the healthcare workforce, and race among health care providers. Six percent felt that their healthcare-related experience were worse than people of other races, 67.7% percent thought they were the same, and 23.6% thought they were better. Eleven percent (11.4%) reported feeling upset as a result of differential treatment they perceived to be due to their race. Twenty-nine percent (29.4%) reported they their race was not represented among the community organizations in the county. Lastly, 22.2% report that more providers of their same race would make them more comfortable sharing health-related information.

Incarceration and Reentry (see complete data in appendices)

The survey assessed issues surrounding incarceration and reentry. A series of questions were asked that assessed the experience of county residents in obtaining or accessing resources due to issues related to incarceration and arrest records. Sixteen percent report they themselves or someone in their household had been incarcerated or arrested in the previous seven years. Almost 2% will have someone returning to their home from being incarcerated in the next five years. Additionally, 4.1% reported than an arrest record or felony has prevented them from obtaining employment and from obtaining other basic necessities including housing or training (2.3%). Lastly it was found that 7.7% of participants reported being aware of county services available to offer assistance to someone reentering the community after being incarcerated.

Community Engagement (see complete data in appendices)

A series of questions were asked to assess the level of awareness of community engagement in the county. Almost 60% thought that county community organizations exist to help with health. Thirty percent report attend such events and 17.6% report being a member of an organization that facilitate health in the county in some way.

Results: Secondary Analyses

In order to better understand the role that several social determinants of health have on the findings, we conducted several bivariate analyses. These analyses include reviewing the results based on income, race, minority status, ethnicity, education, and insurance status.

Comparison Analysis by Income

When inspecting the survey questions by income category (0-$24,999 [0-24K], $25,000-$49,999 [25-49K], $50,000-$74,999 [50-75K], $75,000+ [75K+]), several significant differences were observed. Starting with health screenings or testing, the $25,000-$49,999 income group were less likely to have had HIV testing (answered "no": 0-24K [41.7%], 25-49K [63.5%], 50-75K [50.7%], 75K+ [47.8%]); $\chi^2 = 9.250$, $p<.05$). Additionally, differences were observed in male cancer screenings; the 0-$24,999 income group was less likely to have had a prostate exam (answered "no": 0-24K [65%], 25-49K [26.3%], 50-75K [45%], 75K+ [52.6%]); $\chi^2 = 8.097$, $p<.05$); or a prostate cancer screening (answered "no": 0-24K [83.3%], 25-49K [52.9%], 50-75K [47.6%], 75K+ [61.8%]); $\chi^2 = 9.326$, $p<.025$).

In regards to healthy lifestyle habits, consumption of fruits and vegetables differed by income (answered "3-4" servings per day: 0-24K [28.9%], 25-49K [51.4%], 50-75K [51.4%], 75K+ [36.5%]); $\chi^2= 22.900$, $p<.05$). When asked if they take all the medications prescribed by their physician, differences were observed (answered "no": 0-24K [20.1%], 25-49K [11.1%], 50-75K [4.3%], 75K+ [9.7%]); $\chi^2 = 15.491$, $p<.05$). Survey questions pertaining to health literacy—understanding doctor's instructions (answered "no": 0-24K [62.5%], 25-49K [16.7%], 50-75K [20.8%], 75K+ [0%]);$\chi^2 = 18.849$, $p<.001$), understanding discharge instructions (answered "always": 0-24K [24.6%], 25-49K [17.1%], 50-75K [15.9%], 75K+ [42.3%]); $\chi^2 = 29.862$, $p<.001$), having access to interpreting or translating services (answered "always": 0-24K [11.5%], 25-49K [6.2%], 50-75K [4.9%], 75K+ [1.4%]); $\chi^2 = 29.765$, $p<.001$)—all showed significant differences across income categories.

Significant differences were also present for survey questions asking about family living and common worries; a number of differences were observed. Resident's worries differed based on income category in the following areas: safety (answered "all of the time": 0-24K [34.4%], 25-49K [26.4%], 50-75K [26.5%], 75K+ [15.0%]); $\chi^2 = 31.436$, $p<.002$), finances/money (answered "all of the time": 0-24K [52.7%], 25-49K [34.2%], 50-75K [29.0%], 75K+ [17.0%]); $\chi^2 = 69.815$, $p<.001$), housing payments (answered "all of the time": 0-24K [37.2%], 25-49K [27.0%], 50-75K [20.6%], 75K+ [11.5%]); $\chi^2 = 59.538$, $p<.001$) and affording healthy food (answered "all of the time": 0-24K [35.5%], 25-49K [23.3%], 50-75K [16.7%], 75K+ [7.9%]); $\chi^2 = 84.896$, $p<.001$). There were also differences by income in worries about health care and costs related to health care including worries about paying for medication for yourself (answered "all of the time": 0-24K [30.7%], 25-49K [21.6%],

50-75K [13.0%], 75K+ [10.8%]); χ^2= 51.858, p<.001) and paying for medication for others (answered "all of the time": 0-24K [28.0%], 25-49K [15.5%], 50-75K [13.8%], 75K+ [9.9%]); χ^2 = 30.478, p<.01). When asked about worries regarding care for family in the event of an emergency differences were observed (answered "all of the time": 0-24K [43.2%], 25-49K [22.5%], 50-75K [27.9%], 75K+ [14.2%]); χ^2 = 57.785, p<.001) and worries about job security (answered "all of the time": 0-24K [31.7%], 25-49K [23.2%], 50-75K [16.4%], 75K+ [11.8%]); χ^2 = 35.534, p<.001)

Cost reportedly prevented some residents from receiving care in the following areas; health care for oneself (answered "all of the time": 0-24K [24.4%], 25-49K [12.2%], 50-75K [11.4%], 75K+ [3.0%]); χ^2 = 93.241, p<.001), dental care for oneself (answered "all of the time": 0-24K [35.1%], 25-49K [17.8%], 50-75K [13.0%], 75K+ [5.4%]); χ^2 = 92.960, p<.001), health care for family (answered "all of the time": 0-24K [22.3%], 25-49K [11.3%], 50-75K [10.3%], 75K+ [3.6%]); χ^2 = 57.026, p<.001), dental care for family (answered "all of the time": 0-24K [26.2%], 25-49K [11.4%], 50-75K [17.9%], 75K+ [5.4%]); χ^2 = 52.181, p<.001), paying for medication for yourself (answered "all of the time": 0-24K [26.8%], 25-49K [13.5%], 50-75K [13.0%], 75K+ [4.8%]); χ^2= 82.480, p<.001), and paying for medication for family (answered "all of the time": 0-24K [22.7%], 25-49K [10%], 50-75K [7.4%], 75K+ [4.2%]); χ^2 = 54.218, p<.001).

When survey participants were asked about their mental health in the past thirty days, several questions showed a significant difference. These included feelings of sadness (answered "all or most of the time": 0-24K [23.0%], 25-49K [10.9%], 50-75K [4.0%], 75K+ [5.4%]); χ^2 = 40.411, p<.001), worried (answered "all or most of the time": 0-24K [29.1%], 25-49K [14.7%], 50-75K [9.4%], 75K+ [8.1%]); χ^2 = 41.359, p<.001), nervousness (answered "all or most of the time": 0-24K [25.8%], 25-49K [7.7%], 50-75K [10.8%], 75K+ [5.7%]); χ^2 = 54.218, p<.001), depression (answered "all or most of the time": 0-24K [15.5%], 25-49K [1.6%], 50-75K [1.5%], 75K+ [3.8%]); χ^2 = 45.478, p<.001), hopelessness (answered "all or most of the time": 0-24K [20.4%], 25-49K [6%], 50-75K [3.1%], 75K+ [3.8%]); χ^2 = 45.444, p<.001) and restlessness/fidgety (answered "all or most of the time": 0-24K [21%], 25-49K [6.3%], 50-75K [4.8%], 75K+ [3.2%]); χ^2 = 55.066, p<.001), everything was an effort (answered "all or most of the time": 0-24K [24.6%], 25-49K [3.2%], 50-75K [9.4%], 75K+ [4.4%]); χ^2 = 56.139, p<.001), feelings of worthlessness (answered "all or of the time": 0-24K [15.7%], 25-49K [1.6%], 50-75K [3.2%], 75K+ [2.6%]); χ^2 = 43.721, p<.001), and mental health prevented other activities (answered "all or most of the time": 0-24K [16.8%], 25-49K [4.8%], 50-75K [9.4%], 75K+ [5.1%]); χ^2 = 44.805, p<.001).

Residents also were asked about county resources. Differences were observed by those asked whether county resources were enough to meet their needs (answered "strongly agree or agree": 0-24K [47.4%], 25-49K [55.7%], 50-75K [53.6%], 75K+ [66.5%]); χ^2 = 21.671, p<.05) and when asked if they felt that they had enough access to needed programs and services (answered

"strongly agree or agree": 0-24K [48%], 25-49K [58.2%], 50-75K [54.9%], 75K+ [76.5%]); χ^2 = 37.368, p<.001). Residents were also asked whether their health needs were unique, differences were observed by income (answered "strongly agree to agree": 0-24K [30.7%], 25-49K [16.2%], 50-75K [14.5%], 75K+ [11.6%]); χ^2 = 35.240, p<.001).

Personal health priorities that showed significance included physical activity (answered "strongly agree or agree": 0-24K [58.8%], 25-49K [84.3%], 50-75K [70.1%], 75K+ [75.6%]); χ^2 = 32.236, p<.001), cardiovascular disease (answered "strongly agree or agree": 0-24K [40.0%], 25-49K [49.2%], 50-75K [52.3%], 75K+ [50.7%]); χ^2 = 21.816, p<.05), drug use (answered "strongly agree or agree": 0-24K [31.5%], 25-49K [26.2%], 50-75K [11.3%], 75K+ [16.1%]); χ^2 = 22.540, p<.05), sexually transmitted infections (answered "strongly agree or agree": 0-24K [31.3%], 25-49K [32.2%], 50-75K [12.7%], 75K+ [15.8%]); χ^2 = 24.094, p<.05), and smoking (answered "strongly agree or agree": 0-24K [29.3%], 25-49K [29.6%], 50-75K [12.7%], 75K+ [8.0%]); χ^2 = 37.236, p<.001).

Personal barriers to obtaining health that showed significant differences included transportation (answered "strongly agree": 0-24K [20.8%], 25-49K [10.1%], 50-75K [1.5%], 75K+ [3.1%]); χ^2 = 81.095, p<.001), insurance (answered "strongly agree": 0-24K [34.1%], 25-49K [14.3%], 50-75K [16.2%], 75K+ [3.1%]); χ^2 = 84.954, p<.001), employment (answered "strongly agree": 0-24K [28.6%], 25-49K [7.2%], 50-75K [9.0%], 75K+ [3.7%]); χ^2 = 74.322, p<.001), locating care (answered "strongly agree": 0-24K [16.8%], 25-49K [1.5%], 50-75K [9.1%], 75K+ [2.5%]); χ^2 = 64.554, p<.001), awareness (answered "strongly agree": 0-24K [26.7%], 25-49K [13.2%], 50-75K [6.3%], 75K+ [2.5%]); χ^2 = 75.001, p<.001), mistrust (answered "strongly agree": 0-24K [14.4%], 25-49K [4.5%], 50-75K [6.2%], 75K+ [1.9%]); χ^2 = 49.884, p<.001), finding provider who can communicate in my language (answered "strongly agree": 0-24K [14.9%], 25-49K [7.4%], 50-75K [6.0%], 75K+ [.6%]); χ^2 = 51.960, p<.001), access to health related print material in my language (answered "strongly agree": 0-24K [13.1%], 25-49K [0%], 50-75K [7.6%], 75K+ [0.6%]); χ^2 = 67.862, p<.001), cost (answered "strongly agree": 0-24K [24.6%], 25-49K [14.7%], 50-75K [25.4%], 75K+ [14.9%]); χ^2 = 59.528, p<.001), understanding doctor (answered "strongly agree": 0-24K [15.4%], 25-49K [2.9%], 50-75K [7.5%], 75K+ [0.6%]); χ^2 = 66.789, p<.001), providers not accepting insurance (answered "strongly agree": 0-24K [21.6%], 25-49K [7.5%], 50-75K [12.1%], 75K+ [5.6%]); χ^2 = 46.616, p<.001), not enough time with provider (answered "strongly agree": 0-24K [20.0%], 25-49K [4.5%], 50-75K [4.5%], 75K+ [2.2%]); χ^2 = 48.255, p<.001), finding the right doctor (answered "strongly agree": 0-24K [22.1%], 25-49K [8.7%], 50-75K [12.1%], 75K+ [5.0%]); χ^2 = 37.511, p<.001), poor treatment by providers (answered "strongly agree": 0-24K [18.2%], 25-49K [4.5%], 50-75K [7.5%], 75K+ [4.3%]); χ^2 = 36.536, p<.001), finding a provider that respects cultural and religious beliefs (answered "strongly agree": 0-24K [12.3%], 25-49K [3.0%], 50-75K [4.5%], 75K+ [1.3%]); χ^2

= 42.117, p<.001), and cost of medications (answered "strongly agree": 0-24K [31.1%], 25-49K [17.6%], 50-75K [23.9%], 75K+ [8.1%]); χ^2 = 37.00, p<.001).

Differences in significance also appeared in questions about race. When asked whether they thought their experiences seeking care was the same, worse, or better than others based on race, groups differed by income (answered "better": 0-24K [23.5%], 25-49K [13.7%], 50-75K [21.4%], 75K+ [33%%]); χ^2 = 15.962, p<.05). Residents were also asked if they felt upset due to treatment received that was perceived to be based on race (answered "yes": 0-24K [18.9%], 25-49K [9.5%], 50-75K [12.7%], 75K+ [7.7%]); χ^2 = 15.962, p<.05), whether their race was well represented among providers provider's race (answered "strongly agree": 0-24K [46.6%], 25-49K [60.3%], 50-75K [50.7%], 75K+ [64.5%]); χ^2 = 17.460, p<.01), and whether having a racially concordant provider would improve communication in the patient-provider interaction (answered "yes": 0-24K [32.3%], 25-49K [19.4%], 50-75K [20%], 75K+ [21.2%]); χ^2 = 13.098, p<.05).

Lastly, significance was observed regarding having a cell phone for personal use (answered "no": 0-24K [17.3%], 25-49K [2.7%], 50-75K [4.3%], 75K+ [4.2%]); χ^2 = 23.335, p<.001) and home ownership (answered "home owner": 0-24K [21.9%], 25-49K [35.1%], 50-75K [62.0%], 75K+ [81.0%]); χ^2 = 151.656, p<.001) and "renters" (0-24K [36.5%], 25-49K [51.4%], 50-75K [28.2%], 75K+ [14.3%]); χ^2 = 151.659, p<.001).

Next, the data was reviewed based on self-identified racial group. Differences based on race were explored below.

Comparison Analysis by Race

A number of the survey responses were compared by racial category (White [W], Black/African American [B], Asian [A], Native Hawaii/Pacific Islander [NHPI], American Indian/Alaskan Native [AIAN], Don't Know [DK]. Several interesting patterns emerged. The racial categories did not differ on general health or any other health related factor. Significant differences were observed in two of the language questions including those that asked about need for translation services (answered "always" W [55.6%], B [16.7%], A [5.6%], NHPI [0%], AIAN [5.6%], DK [16.7%]; χ^2 = 49.881, p <.01) and level of understanding of provider instructions (answered "always" W [67.9%], B [25.6%], A [2.3%], NHPI [0.3%], AIAN [3.1%], DK [0.9%]; χ^2 = 27.815, p <.05).

Next we inquired about some family life factors. The racial groups did differ on worries about safety (answered "all of the time" W [58.1%], B [36.2%], A [2.9%], NHPI [0%], AIAN [0%], DK [2.9%]; χ^2 = 40.008, p <.01). We also asked participants if cost had ever impacted care for themselves or a family member. The groups differed on the majority of these factors where cost prevented healthcare for themselves (answered "all of the time" W [58.3%], B [33.3%], A [2.1%], NHPI [0%], AIAN [0%],

DK [6.3%]; χ^2 = 39.844, p <.01); dental care for themselves (answered “all of the time” W [62.7%], B [28.4%], A [0%], NHPI [0%], AIAN [1.5%], DK [7.5%]; χ^2 = 33.519, p <.05); health care for a family member (answered “all of the time” W [56.8%], B [36.4%], A [0%], NHPI [0%], AIAN [0%], DK [6.8%]; χ^2 = 35.011, p <.05); paying for medication for themselves (answered “all of the time” W [61.8%], B [29.1%], A [0%], NHPI [0%], AIAN [1.8%], DK [7.3%]; χ^2 = 32.149, p <.05), and paying for medication for a family member (answered “all of the time” W [60.5%], B [32.6%], A [0%], NHPI [0%], AIAN [0%], DK [7.0%]; χ^2 = 32.094, p <.05).

The racial groups did not differ on experiencing pain or mental health needs in the previous 30 days. However, of those that experienced pain or a mental health need in the previous 30 days, there were difference in who sought care for their needs ((answered “yes” W [68.1%], B [18.1%], A [5.6%], NHPI [1.4%], AIAN [5.6%], DK [1.4%]; χ^2 = 27.701, p <.05).

There were differences observed when we asked about individual health priorities. There were racial differences in reporting weight has a health priority (answered “strongly agree” W [61.1%], B [31.5%], A [4.7%], NHPI [0.0%], AIAN [0.7%], DK [2.0%]; χ^2 = 54.043, p <.01) and diabetes (answered “strongly agree” W [50.0%], B [40.3%], A [5.6%], NHPI [0%], AIAN [2.8%], DK [1.4%]; χ^2 = 38.063, p <.01). The survey also asked about barriers to care. Several barriers had significant differences by racial group: Awareness of available services (answered “strongly agree” W [47.6%], B [33.3%], A [2.4%], NHPI [0%], AIAN [4.8%], DK [11.9%]; χ^2 = 40.593, p <.01), mistrust of programs and services (answered “strongly agree” W [60.0%], B [25.%], A [10.%], NHPI [0%], AIAN [5.0%], DK [0%]; χ^2 = 34.023, p <.05), finding services with a way to communicate (answered “strongly agree” W [68.2%], B [22.7%], A [0%], NHPI [0%], AIAN [0%], DK [9.1%]; χ^2 = 41.990, p <.01), and access to printed material and doctor’s instructions in my language (answered “strongly agree” W [66.7%], B [33.3%], A [0%], NHPI [0%], AIAN [0%], DK [0%]; χ^2 = 36.423, p <.05).

We also asked a few questions on the role of race in their health care. There were significant differences with regard to whether they felt that their race impacted their care (answered “yes” W [43.1%], B [45.1%], A [2.0%], NHPI [3.9%], AIAN [5.9%], DK [0%]; χ^2 = 41.726, p <.01), that their racial group was well represented among available providers (answered “no” W [52.1%], B [34.3%], A [7.1%], NHPI [1.4%], AIAN [2.1%], DK [1.9%]; χ^2 = 33.121, p <.01), and whether having a race concordant provider would positively impact their care and communication with their provider (answered “yes” W [50.5%], B [35.8%], A [1.1%], NHPI [2.1%], AIAN [4.2%], DK [6.3%]; χ^2 = 34.389, p <.01).

Lastly, there were differences on home status, for example owing vs. renting (answered “own home” W [76.3%], B [17.3%], A [2.4%], NHPI [0.8%], AIAN [2.8%], DK [0.4%] or answered “rent home” W [49.2%], B [39.5%], A [4.0%], NHPI [0%], AIAN [1.6%], DK [5.6%]; χ^2 = 23.335, p <.01).

In order to better explore these results, racial groups were grouped dichotomously into Minority vs. Non-Minority, differences based on Minority status were explored below.

Comparison Analysis by Minority Status

Several interesting patterns emerged when the data was analyzed by comparing differences between Minorities (all except White) and Non-minorities (White only). The dichotomous minority categories did not differ on general health or any other health related factor.

Next, family life factors were explored. The dichotomous minority categories did differ on "worries about safety" (30.6% vs. 20.3%; $\chi^2 = 14.954$, $p < .01$), non-minority were less likely to worry about safety compared to minority groups. While non-significant, there was trend toward significance with a few of the questions that are worth mentioning: "worry about housing payments" (19.4% vs. 23.3%; p=.070) with minorities being more likely to report this worry happen all, most or some of the time; minorities were more likely to report that they in the previous 30 days felt "healthy and full of energy" none of the time (27.3% vs. 15.5%; p=.080).

There were differences observed when we asked about individual health priorities. There were differences by minority status in those reporting weight as a health priority (40.7% vs. 30.6%; $\chi^2 = 12.283$, $p < .05$), minorities were more likely to strongly agree that weight was a personal health priority. Minorities were also more likely to strongly agree that cardiovascular disease (25.6% vs. 16.5%; $\chi^2 = 9.642$, $p < .05$) and diabetes (28.2% vs. 13.1%; $\chi^2 = 15.114$, $p < .01$) was a personal health priorities. Non-minorities were more likely to identify oral health ("strongly agree to agree" 61.4% vs. 50.8%; $\chi^2 = 14.662$, $p < .01$) and cancer as health priorities ("strongly agree to agree" 48.3% vs. 37.8%; $\chi^2 = 10.607$, $p < .05$). Minorities were more likely to strongly agree that sexually transmitted diseases were a health priority (15.4% vs. 8.2%; $\chi^2 = 10.551$, $p < .05$).

The survey also asked about barriers to care. Minorities were more likely to strongly agree that "awareness of available services" was a barrier ($\chi^2 = 11.618$, $p < .05$).

There were a few questions on the role of race in their health care. Minorities were more likely to report that in the last 30 days they felt upset about treatment that they have received perceived to be based on race (20.9% vs. 7.4%; $\chi^2 = 18.101$, $p < .001$). There were non-significant differences, but with a trend toward significance, with regard to whether they felt that their race impacted their care, non-minorities were more likely to report that they felt their health care was better due to their race (27.3% vs. 18.0%; $\chi^2 = 5.347$, $p = .069$). Conversely, minorities were more likely to report that their racial group was not well represented (46.3% vs. 24.6%; $\chi^2 = 23.110$, $p < .001$), and that having a race concordant provider would positively impact their care and communication with their provider (30.6% vs. 16.7%; $\chi^2 = 11.716$, $p < .01$).

Lastly, there were differences between home ownership and renting, non-minorities were more likely to own their home (63.3% vs. 41.4%; χ^2 = 23.395, p <.001) and minorities were more likely to rent (40.0% vs. 20.3%).

Next, the data was reviewed based on ethnicity. Individuals self-identified as Hispanic or Non-Hispanic, differences based on Ethnicity was explored below.

Comparison Analysis by Ethnicity

Several interesting patterns emerged when the data was analyzed by comparing differences between Non-Hispanic and Hispanic. The dichotomous ethnicity categories did not differ on general health, however a few significant associations among other health related factors were observed. Differences were observed in history of a having mammogram, were Hispanic females were less likely to reporting having a mammogram (55.3% vs. 78.7%; χ^2 =15.593, p <.001), having a pap smear to screen for cervical cancer (68.4% vs. 83.5%; χ^2 =13.310, p <.001), and having a colonoscopy (34.2% vs. 63.7%; χ^2 =14.128, p <.001).

The groups also differed on consumption of fruits and vegetables (16.6% vs. 8.3%; χ^2 15.610, p <.05), non-minorities were more likely to report consuming five or more vegetables per day, similarly Hispanics were more likely to report only consuming 1-2 servings of fruits and vegetables per day (58.3% vs. 38.8%). Differences also existed with reported number of days exercising (46.7% vs. 26.3%; χ^2 =21.728, p <.05), Hispanics were more likely to report engaging in none to very little exercise.

Non-Hispanics were more likely to report having a regular physician (85.4% vs. 60.7%; χ^2 =24.229, p <.001),

The groups did not differ significantly, but a trend toward significance is worth mentioning on a few of these factors where cost impacted healthcare for themselves (χ^2 = 14.139, p =.078) and paying for medication for a family member (χ^2 = 14.218, p =.076).

There were differences observed when we asked about individual health priorities. There were differences by ethnicity in those reporting weight as a health priority, Hispanics were less likely to “disagree” that weight was a priority (6.7% vs., 11.9%; χ^2 = 25.816, p <.001) and Hispanics were more likely to “strongly agree or agree” that cardiovascular disease was a priority (51.9% vs. 47%; χ^2 15.501, p <.05). There were also trends (non-significant) found between Hispanics or Non-Hispanics in diabetes as a health priority (χ^2 = 14.463, p =.070) and injury as a health priority (41.5% vs. 25.5%; χ^2 =15.113, p =.057), where non-Hispanics were likely to “strongly agree” that these were health priorities.

Comparison Analysis by Age Category

Next, the data was explored for associations based on age. Participants were grouped by age (under 64 years of age and 65 and older). Several interesting patterns emerged when the data was analyzed by comparing differences between younger and older residents.

The dichotomous age categories did not differ on general health or any other health related factor. Next we inquired about some family life factors. The dichotomous age categories did differ on "worries"; those under 64 years of age were more likely to report worry about money (35.7% vs. 13.7%; $\chi^2 = 30.282$, $p < .001$), housing payments (26.1% vs. 6.9%; $\chi^2 = 64.576$, $p < .001$), affording healthy foods (23.4% vs. 6.8%; $\chi^2 = 21.299$, $p < .001$) "all of the time", job security (24.4% vs. 1.6%; $\chi^2 = 85.288$, $p < .001$), "all of the time", health care for yourself (21.3% vs. 3.8%; $\chi^2 = 21.896$, $p < .001$) all or most of the time, dental care of yourself (31.7% vs. 9.4%; $\chi^2 = 21.060$, $p < .001$), Health care of family (20.2% vs. 2.8%; $\chi^2 = 20.784$, $p < .001$), dental care for family (25.1% vs. 5.5%; $\chi^2 = 25.739$, $p < .001$), all or most of the time. Paying for medication for yourself (22.8% vs. 9.3%; $\chi^2 = 18.175$, $p < .001$) and paying for medication for family (20.8% vs. 5.6%; $\chi^2 = 25.898$, $p < .001$), all or most of the time.

When asked about whether cost impacted health care for themselves or their family, participants under 64 years of age were more likely to report that cost impact their personal medication costs (21.2% vs. 7.9%; $\chi^2 = 25.591$, $p < .001$), medication for others in their family (19.0% vs. 7.8%; $\chi^2 = 21.941$, $p < .001$), health care for their family (29.7% vs. 9.7%; $\chi^2 = 24.101$, $p < .001$), "all of the time".

Those 65 and older were more likely to report that they in the previous 30 days felt "sad" none of the time (66.7% vs. 45.9%; $\chi^2 = 11.359$, $p < .05$), "worried" a little or none of the time (80.9% vs. 52.4%; $\chi^2 = 24.559$, $p < .001$),) "healthy and full of energy" all or most of the time (62.8% vs. 38.4%; $\chi^2 = 20.723$, $p < .001$), felt "nervous" none of the time (72.3% vs. 41.2%; $\chi^2 = 22.166$, $p < .001$), felt "hopeless" none of the time (92.4% vs. 62.3%; $\chi^2 = 23.061$, $p < .001$), felt "fidgety" none of the time (74.2% vs. 54.9%; $\chi^2 = 10.601$, $p < .05$), felt that everything took "effort" none of the time (87.9% vs. 59.6%; $\chi^2 = 20.069$, $p < .001$).

When asked about recent doctor visits for symptoms, participants over the age of 65 were more likely to report "yes" (26.7% vs. 13.4%; $\chi^2 = 8.382$, $p < .05$). When asked whether county resources were adequate to meet their health needs (77.6% vs. 53.6%; $\chi^2 = 17.620$, $p < .001$), participants over the age of 65 were more likely to strongly agree and agree, similarly for whether county services were able to address their needs (65.2% vs. 50.5%; $\chi^2 = 11.770$, $p < .05$), and access to those services (81.3% vs. 58%; $\chi^2 = 14.559$, $p < .01$).

There were differences observed when we asked about individual health priorities. Residents over 65 also more likely to strongly disagree that diabetes (25.0% vs. 14.3%; $\chi^2 = 10.517$, $p < .05$) was a personal health priorities. Residents under 64 were more likely to strongly agree that healthy eating (34.4% vs. 12.1%; $\chi^2 = 18.997$, $p = .001$), sexual and reproductive health (17.2% vs. 4.8%; $\chi^2 = 12.583$, $p = .05$), and mental health (24.5% vs. 6.7%; $\chi^2 = 17.324$, $p = .01$) were health priorities.

The survey also asked about barriers to care. Residents 64 and under were more likely to strongly agree or agree that insurance (34.8% vs. 5.9%; $\chi^2 = 23.360$, $p < .001$), employment issues (27.3% vs. 3%; $\chi^2 = 20.719$, $p < .001$), locating care (17.3% vs. 0%; $\chi^2 = 17.654$, $p = .001$), awareness of available services (30.7% vs. 15.1%; $\chi^2 = 9.980$, $p < .05$), costs (33.4% vs. 8.8%; $\chi^2 = 18.453$, $p < .001$), doctors accepting insurance plan (25.8% vs. 8.8%; $\chi^2 = 11.422$, $p < .05$), problem locating the right doctor (30.4% vs. 10.5%; $\chi^2 = 11.642$, $p < .05$), treatment by providers and staff (23.1% vs. 4.5%; $\chi^2 = 12.024$, $p < .05$), costs of prescriptions (39.5% vs. 18.2%; $\chi^2 = 11.950$, $p < .05$) were all personal barriers to health or health care. There was a trend toward significance with residents under 64 were more likely strongly agree or agree that transportation was a personal barrier to health and/or health care (18.4% vs. 4.5%; $\chi^2 = 8.838$, $p = .065$).

There were a few questions on the role of race in their health care. Residents under the age of 64 were more likely to were more likely to report that their racial group was not well represented (34.3% vs. 14.9%; $\chi^2 = 11.949$, $p < .01$).

. Residents over 65 were more likely to were more likely to report not having a personal cell (14.7% vs. 6.2%; $\chi^2 = 6.22$, $p < .05$). Lastly, there were differences on home status, for example owing vs. renting, those over 65 were more likely to own their home (77.9% vs. 49.2%; $\chi^2 = 21.966$, $p < .001$) and younger residents were more likely to rent (31.8% vs. 15.6.3%).

Next, the data was reviewed based on education.

Comparison Analysis by Education Category

Several interesting patterns emerged when the data was analyzed by comparing differences between those who had completed high school or less versus those who completed at least some college or more. The dichotomous education categories did not differ on general health but interestingly, did differ significantly on history of having a HIV test, with the lower education group being less likely to have had a HIV test compared to the higher education group (60.6% vs. 49.3%; $\chi^2 = 4.778$, $p < .05$). Among men, we also observed differenced in history of a PSA (prostate specific antigen screening using for prostate cancer) and a colonoscopy, the higher education group of men being more likely to have had a PSA screening (43.6% vs. 22.9%; $\chi^2 = 4.447$ $p < .05$) and a colonoscopy (50% vs. 29.4%; $\chi^2 = 4.107$, $p < .05$).

Among health behaviors, some significant associations were observed. The lower education group were more likely to have a smoking history (21.5% vs. 11.9.1%; $\chi^2 = 7.714$, $p < .05$). There was a trend toward significance for number of days exercised ($\chi^2 = 10.249$, $p = .068$), with the higher education group reporting more days compared to the lower education group.

When asked about need/use of an interpreter or translator for medical visits, the lower education group was more likely to acknowledge always or sometimes needing these services compared to the higher education group (16.6% vs. 7.2%; $\chi^2 = 28.821$, $p < .001$). Similarly, there were differences observed in ability to understand discharge instructions, with the lower education group being less likely to "always" understand their doctor's instructions (67.2% vs. 82.9%; $\chi^2 = 15.969$, $p < .001$).

Next we inquired about some family life factors. The dichotomous education categories did differ with the lower education group being more likely to worry "all of the time" compared to the higher education group with regard to "safety" (30.6% vs. 20.3%; $\chi^2 = 23.936$, $p < .001$), money (44.8% vs. 26.6%; $\chi^2 = 16.586$, $p < .01$), housing payments (39.5% vs. 15.8%; $\chi^2 = 45.872$, $p < .001$), affording healthy food (34.7% vs. 13.9%; $\chi^2 = 33.956$, $p < .001$), personal medication costs (31.1% vs. 13.9%; $\chi^2 = 26.416$, $p < .001$), paying for medications for others (29.9% vs. 11.2%; $\chi^2 = 29.942$, $p < .001$), caring for family (49.2% vs. 17.2%; $\chi^2 = 61.693$, $p < .001$), job security (31.6% vs. 15.3%; $\chi^2 = 24.984$, $p < .001$).

When asked about whether cost has ever impacted receiving health care for themselves or a family member, groups differed significantly. The lower education group was more likely to report that cost impacting health care "all of the time" including health care for themselves (26.0% vs. 6.4%; $\chi^2 = 57.764$, $p < .001$), dental care for themselves (26.8% vs. 13.0%; $\chi^2 = 29.942$, $p < .001$), health care for their family (23.2% vs. 6.3%; $\chi^2 = 46.565$, $p < .001$), dental care of their family all or most of the time (39% vs. 13.6%; $\chi^2 = 38.330$, $p < .001$), paying for medication for themselves all or most of the time (39.2% vs. 14.8%; $\chi^2 = 53.312$, $p < .001$), and paying for mediation for their family all or most of the time (37.4% vs. 11.3%; $\chi^2 = 48.986$, $p < .001$). Additionally, the lower education group were more likely to report that they in the previous 30 days felt "healthy and full of energy" some of the time (30.9% vs. 20.1%; $\chi^2 = 11.704$, $p < .05$), less likely to report no feelings of helplessness (57.8% vs. 71.3%; $\chi^2 = 15.714$, $p < .01$), and more like to report feeling depressed all of the time(7.1% vs. 2.5%; $\chi^2 = 9.706$, $p < .05$), and feeling worthless all of the time (7.2% vs. 2.6%; $\chi^2 = 11.130$, $p < .05$).

When asked whether their health was the same at the typical Frederick County resident, lower education residents were more likely to strongly agree or agree" (57.2% vs. 41.5%; $\chi^2 = 10.995$, $p < .05$). When asked whether they had unique health problems (26% vs. 14.7%; $\chi^2 = 12.674$, $p < .05$), lower education residents were more likely to strongly agree and agree.

There were differences observed when we asked about individual health priorities. There were differences by education level in those reporting smoking as a health priority (30.2% vs. 14.2%; $\chi^2 = 18.375$, $p < .001$), lower education residents were more likely to "strongly agree or agree" that smoking was a personal health priority.

The survey also asked about barriers to care. Lower education residents were more likely to "strongly agree or agree" that the following were barriers; transportation (31.8% vs. 10.7%; $\chi^2 = 31.735$, $p < .001$), insurance (44.0% vs. 25.1%; $\chi^2 = 18.591$, $p < .001$), employment (39.5% vs. 18.8%; $\chi^2 = 22.774$, $p < .001$), locating care (30.0% vs. 10.7%; $\chi^2 = 29.043$, $p < .001$), awareness of available services (41.3% vs. 23.6%; $\chi^2 = 20.881$ $p < .001$), mistrust of programs and services (28.6% vs. 12%; $\chi^2 = 17.858$, $p < .001$), finding services where they communicate in specific language (25.7% vs. 6.5%; $\chi^2 = 36.669$, $p < .001$), access to materials in specific language (25.5% vs. 5.3%; $\chi^2 = 42.573$, $p < .001$), costs (42.9% vs. 26.5%; $\chi^2 = 16.641$, $p < .01$), understanding their provide (26.6% vs. 8.3%; $\chi^2 = 30.040$, $p < .001$), not enough time with provider (37.5% vs. 22.9%; $\chi^2 = 10.156$, $p < .05$), finding the right doctor (38.1% vs. 23.2%; $\chi^2 = 11.873$, $p < .05$), finding a provider that respects cultural or religious needs (21.6% vs. 6.8%; $\chi^2 = 22.981$, $p < .001$). There was a trend toward significance with programs and services not accepting insurance as a barrier (33.9% vs. 19.9%; $\chi^2 = 9.345$, $p = .053$).

There were a few questions on the role of race in their health care. Those in the lower education group were more likely to report that in the last 30 days they felt upset about treatment that they have received perceived to be based on race (15.7% vs. 10.2%; $\chi^2 = 8.179$, $p < .05$) and that their racial group was not well represented (35.7% vs. 28.4%; $\chi^2 = 14.957$, $p < .001$), and that having a race concordant provider would positively impact their care and communication with their provider trending toward significance (31.0% vs. 20.6%; $\chi^2 = 5.610$, $p = .061$).

Lastly, there were differences on home status, for example owing vs. renting, the higher educated group were more likely to own their home (60.4% vs. 34.4%; $\chi^2 = 27.487$, $p < .001$) and the lower education group were more likely to rent (38.9% vs. 25.1%). Additionally, the lower education group were more likely to report not owning a cell phone for personal use (14.8% vs. 6.1%; $\chi^2 = 9.061$, $p < .01$).

Next, the data was reviewed based on insurance status. Individuals self-identified as either being insured or not, these differences were explored below.

Comparison Analysis by Insurance Status

Several interesting patterns emerged when the data was analyzed by comparing differences between insured and uninsured residents. The dichotomous insurance categories did not yield ay significant differences in general health or any other health related factor. However, a trend toward significance was observed in general health (51.8% vs. 43.1%; $\chi^2 = 8.923$, $p = .063$) where the

insured groups were more likely to report “excellent or very good health” compared to the uninsured group.

When asked about need/use of an interpreter or translator for medical visits, the uninsured group was more likely to acknowledge “always or sometimes” needing these services compared to the insured group (30.7% vs. 6.1%; $\chi^2 = 53.997$, $p < .001$). Similarly, there were differences observed in ability to understand discharge instructions, with the lower education group being less likely to “always” understand their doctor’s instructions (82.1% vs. 96.0%; $\chi^2 = 17.811$, $p < .001$) and to “always” understand discharge instructions (57.1% vs. 81.7%; $\chi^2 = 20.816$, $p < .001$).

Next we inquired about some family life factors. The dichotomous insurance categories did differ on “worries”, uninsured residents were more likely to “always” worry about the following compared to insured residents: safety (46.6% vs. 21.7%; $\chi^2 = 18.666$, $p < .001$), housing payments (37.5% vs. 19.7%; $\chi^2 = 13.255$, $p < .05$), affording healthy food (42.6% vs. 16.2%; $\chi^2 = 29.314$, $p < .001$), personal medication costs (35.1% vs. 15.9%; $\chi^2 = 21.411$, $p < .001$), paying for medication for others (30.8% vs. 14.2%; $\chi^2 = 12.873$, $p < .05$), caring for family (47.5% vs. 22.8%; $\chi^2 = 18.825$, $p < .001$), and employment (35.5% vs. 17.4%; $\chi^2 = 15.454$, $p < .01$)..

When asked about whether cost has ever impacted receiving health care for themselves or a family member, groups differed significantly. The uninsured group was more likely to report that cost impacting health care “all of the time” including health care for themselves (33.9% vs. 8.5%; $\chi^2 = 64.357$, $p < .001$), dental care for themselves (43.9% vs. 13.0%; $\chi^2 = 50.209$, $p < .001$), health care for their family (35.7% vs. 7.3%; $\chi^2 = 76.809$, $p < .001$), dental care of their family all or most of the time (53.7% vs. 17.1%; $\chi^2 = 59.006$, $p < .001$), paying for medication for themselves all or most of the time (57.2% vs. 15.7%; $\chi^2 = 78.356$, $p < .001$), and paying for mediation for their family all or most of the time (54.7% vs. 13%; $\chi^2 = 84.394$, $p < .001$). Additionally, uninsured group were more likely to report that they in the previous 30 days felt sad “all or most of the time” (18% vs. 11.2%; $\chi^2 = 12.211$, $p < .05$), hopeless “all or most of the time” (15.7% vs. 7.8%; $\chi^2 = 16.598$, $p < .01$), fidgety “some to all of the time” (38.5% vs. 20.2%; $\chi^2 = 11.688$, $p < .05$), required effort “some to all of the time” (34.7% vs. 18.8%; $\chi^2 = 10.167$, $p < .05$), feeling worthless “some to all of the time” (27.7% vs. 11.3%; $\chi^2 = 12.168$, $p < .05$).

When asked whether their health needs were being met by Frederick County services, insured residents were more likely to “strongly agree or agree” that their needs were being met (59.8% vs. 42.15%; $\chi^2 = 15.069$, $p < .01$). When asked whether services are adequate to address their issues, uninsured resident were more likely to “strongly disagree or disagree” (24.1% vs. 10.8%; $\chi^2 = 10.378$, $p < .05$), enough access to services (32% vs. 13.1%; $\chi^2 = 14.957$, $p < .01$). When

asked whether they had unique health problems (37% vs. 15.1%; $\chi^2 = 17.501$, $p < .01$), uninsured residents were more likely to strongly agree and agree.

There were differences observed when we asked about individual health priorities. The uninsured were more likely to identify oral health ("strongly agree to agree" 68.3% vs. 57%; $\chi^2 = 11.179$, $p < .05$), smoking as health priorities ("strongly agree to agree" 39.6% vs. 15.4%; $\chi^2 = 18.908$, $p < .001$), and asthma (45.2% vs. 24.8%; $\chi^2 = 10.719$, $p < .05$). Trends toward significance were observed in personal health priorities that include diabetes (27.3% vs. 16.3%; $\chi^2 = 9.232$, $p = .056$), mental health (38.1% vs. 19.3%; $\chi^2 = 8.632$, $p < .071$), and sexually transmitted diseases ("strongly agree or agree" 39.1% vs. 20.1%; $\chi^2 = 8.830$, $p = .065$) where the uninsured were more likely to report these health priorities versus insured residents.

The survey also asked about barriers to care. Uninsured residents were more likely to "strongly agree or agree" that the following were barriers; transportation (43.5% vs. 12.4%; $\chi^2 = 33.244$, $p < .001$), insurance (82.0% vs. 22.9%; $\chi^2 = 99.421$, $p < .001$), employment (62.7% vs. 18.8%; $\chi^2 = 76.303$, $p < .001$), locating care (43.5% vs. 12%; $\chi^2 = 41.547$, $p < .001$), awareness of available services (63.8% vs. 23.5%; $\chi^2 = 52.241$ $p < .001$), mistrust of programs and services (45.5% vs. 12.4%; $\chi^2 = 48.166$, $p < .001$), finding services where they communicate in specific language (41.7% vs. 7.3%; $\chi^2 = 57.412$, $p < .001$), access to materials in specific language (37.5% vs. 6.7%; $\chi^2 = 48.532$, $p < .001$), costs (67.4% vs. 26.2%; $\chi^2 = 41.138$, $p < .001$), understanding their provide (32.6% vs. 10.2%; $\chi^2 = 33.079$, $p < .001$), finding someone who accepts health insurance (39.2% vs. 21.3%; $\chi^2 = 14.450$, $p < .01$), not enough time with provider (46.8% vs. 24.1%; $\chi^2 = 28.484$, $p < .001$), finding the right doctor (47.9% vs. 24.3%; $\chi^2 = 15.302$, $p < .01$), treatment (e.g., personal interactions by staff and providers (37% vs. 18.5%; $\chi^2 = 16.838$, $p < .01$), finding a provider that respects cultural or religious needs (27.7% vs. 8.1%; $\chi^2 = 26.571$, $p < .001$), and cost of medications (71.1% vs. 31.8%; $\chi^2 = 38.199$, $p < .001$).

There were a few questions on the role of race in their health care. The uninsured were more likely to report feeling that they received "worse" care based on their race (15.8% vs. 4.9%; $\chi^2 = 10.02$, $p < .01$). Uninsured residents also were more likely to report that having a race concordant provider would positively impact their care and communication with their provider (42.9% vs. 20.4%; $\chi^2 = 17.091$, $p < .001$).

Lastly, there were differences on home status, for example owing vs. renting, insured residents were likely to own their home (58.0% vs. 20.3%; $\chi^2 = 39.710$, $p < .001$) and minorities were more likely to rent (47.5% vs. 26.3%). Uninsured residences were more likely to report not owning a cell phone for personal use (19.3% vs. 6.7%; $\chi^2 = 10.613$, $p = .001$).

NEEDS ASSESSMENT: SUMMARY OF COMMUNITY STRUCTURED INTERVIEWS

Community Structured Interviews

Community Members, Leaders, and Providers

After conducting interviews with 20 Frederick County community members, leaders, or providers, a diverse set of information was gathered and analyzed thematically. Beginning with the organization/individual characteristics, interviews were held with a range of professionals from CEOs to organization directors, advocates, medical providers, and reverends among others. Interviewees had 16 months to 18 years of experience in their specific fields of study with some of them working anywhere from 2 hours a week in their position to as much as 80 hours a week.

Table 7: Characteristics of the Interviewees	
Living in Frederick County	% (n)
Yes	70% (14)
No	30% (6)
Time spent doing the following activities	
Leading	
Less Than 10%	10% (2)
10-25%	10% (2)
25-50%	35% (7)
50-75%	20% (4)
75-100%	25% (5)
Managing	
Less Than 10%	15% (3)
10-25%	15% (3)
25-50%	35% (7)
75-100%	35% (7)
Advocating	
Less Than 10%	15% (3)
10-25%	40% (8)
25-50%	20% (4)
50-75%	5% (1)
75-100%	20% (4)
Ability to negotiate with leaders from other organizations in the community	
Very Good	75% (15)
Somewhat Good	25% (5)
Frequency Of Engagement In Collaborative Efforts With Local Leaders	
Daily	15% (3)
Several Times A Week	30% (6)
2-3 Times Per Month	20% (4)
Once A Month	10% (2)
Several Times A Year	20% (4)
Don't know	5% (1)
Frequency Of Personal Interaction With The Programs And Services Provided By Own Organization	
Rarely	15% (3)
Sometimes	5% (1)
Often	65% (13)
Don't Know	5% (1)

Organization's Health Participation

Interviewees were asked a series of questions that assessed their personal and organizational involvement in improving the health of the community in Frederick County. Most reported that their organization was involved with improving care and access to under-served or low-income populations or communities, or supporting the dissemination of health information and education.

Table 8: Organizational Perceptions of Health Priorities	*% (#)*
Health is a Priority of the Organization	
Large Priority	60% (12)
A Priority	25%(5)
A Small Priority	5%(1)
Not A priority	5%(1)

The most common health services were focused on mental health among county residents. Most interviewees expressed that diabetes programs were the most successful, and the least successful were programs focused on mental health and physical activity. Mental health programs failed on account of the great need and lack of resources, and physical activity programs were few, greatly needed, but also proved difficult due to the inherent habit-changing that is necessary.

Table 9: Organization's Health Participation	*% (#)*
Organization's Health Related Programs and Services	
Diabetes/Cardiovascular Disease	45% (9)
Weight	40% (8)
Physical Activity	50% (10)
Diet/Nutrition	55% (11)
HIV/AIDS	25% (5)
Mental Health	65% (13)
Smoking Cessation	35% (7)
Programs Targeting Youth	35% (7)
Oral Health	30% (6)
LGBTQ Programs/Services	10% (2)

On average, less than 10% percent of the community participates in health related programs; however, this does not reflect reported accessibility (location) or reach.

Most organizations share their health information through educational classes, brochures, or social media. Over 80% reported to have Facebook pages.

Although these organizations try to target all county residents, mostly older and female residents, along with families, participate.

Resources or assets organizations offered to promote health in the community included health education classes, physical activity events, mental wellness promotion, smoking cessation classes, and diabetes support groups.

Table 10: Participation and Outreach Methods	
Percent Of Community that Participates in Health Related Programs	% (n)
<10%	30% (6)
10-25%	15% (3)
25-50%	10% (2)
50-75%	10% (2)
None	15% (3)
Percentage Of Community that Participates in Non Health Related Programs	
Less Than 10%	25% (5)
10-25%	10% (2)
25-50%	5% (1)
50-75%	20% (4)
None	15% (3)
Percent Of People Using Services Feeling Personally Acquainted With	
Less Than 10%	30% (6)
10-25%	10% (2)
25-50%	15% (3)
50-75%	15% (3)
75-100%	20% (4)
None	5% (1)
Don't Know	5% (1)
Ways Of Sharing Health Information	
Social Media	65% (13)
Social Media Page e.g., Facebook	
Yes	80% (16)
No	20% (4)
Faith-Based Efforts	35% (7)
Health Care Related Mobile App	15% (3)
Health Information Website	55% (11)
Health Related Banners, Posters or Signs	40% (8)
Health Brochures, Flyers, Or Other Printed Health Materials	80% (16)
Health Magazines	15% (3)
Health Related Classes or Workshops	80% (16)
Health Related Videos	25% (5)

Frederick County Health

When asked various questions regarding the health of Frederick County residents, participating stakeholders were presented a Likert Scale to report each response. Participants were asked if the health of Frederick County residents is worse than that of other counties residents, most (85%) chose the neutral to disagree scales. When asked if the health services are adequate and reflected the community need, 12 of the 20 disagreed with the statement.

Three of the top health priorities included weight management, eating properly, and cancer prevention.

The top three barriers to health care access were transportation, lack of awareness of services and issues relating to costs, insurance and payment.

Interviewees indicated that resources are scarce to implement programs, dental and oral health care hardly exists, mental health services are lacking or inadequate as our psychiatrists, and substance abuse services.

The interviewees were also asked some open–ended questions that focused on their personal thoughts and abilities to impact health. When asked about challenges that are faced by the organizations, securing funding resources was a principal obstacle. Others that were mentioned were lack of collaboration between organizations providing similar services, and communication between residents and county health officials. LGBTQ issues arose as needing comprehensive attention from the county as well—services for LGBTQ residents should expand out into the rural areas and not just the city.

When asked how health promotion can be improved in the county, most respondents said health communication and dissemination needs attention. Suggestions included clearer messaging, audience appropriate material, innovative program marketing, and appropriate health literacy, increase use of social media and technology, and linguistic variability of printed material.

Interviewees were asked what they would like to see happen in Frederick County and their community as it relates to health. Many responded that they would like to see better mental health services; further, some said that they wanted to see better integration of mental health services with physical health services. Other issues mentioned were early childhood interventions, especially as it relates to obesity; community-based physical activities and events where community members can be part of the planning; and lastly, the adequate care of the LGBTQ community by all types of medical providers.

NEEDS ASSESSMENT: SUMMARY OF COMMUNITY FOCUS GROUPS

Focus Group Sessions

INTRODUCTION- Seeking Community Opinion

The Frederick Memorial Hospital and Frederick County Health Department partnered with The George Washington University Milken Institute School of Public Health to sponsor a Health Needs Assessment in Frederick County, Maryland. A mixed method approach was used to assess the needs, identify resources, and identify opportunities for intervention.

This needs assessment consisted of three distinct parts: a community needs assessment survey, focus groups and structured interviews. Part 2 of the project consisted of focus groups meetings. This report summarizes the findings of these meetings.

METHODOLOGY

The Project Coordinator, with guidance from staff at Frederick Memorial Hospital was responsible for contacting various organizations to host focus groups with targeted groups. Populations that were targeted for focus group were:

- Frederick Integrated Health Network (FIHN) Board of Directors…….
- Senior Citizens…….
- Frederick Memorial Hospital Lay Health Educators……...
- Spanish speaking residents……...
- Brunswick Providers…….
- Homeless Individuals……..

These meetings were held between January 5, 2016 and February 24, 2016. A total of six focus groups were conducted with a total sample of n = 49. Each focus group meeting lasted 60-120 minutes and consent forms for focus group participants were completed in advance by all those seeking to participate. Certain populations were targeted and recruited for focus groups based on 1) limited access to a particular population during the survey recruitment or 2) a specialized group that was believed to possess key information and experiences. Groups were targeted and recruited by liaisons at the following organizations: Urbana Senior Center, Frederick Integrated Health Network (FIHN) Board of Directors, Frederick Memorial Hospital, Centro Hispano, Frederick Primary Care Associates, and Religious Coalition. Participants were provided with a $15 gift card for their input.

The participants represented organizations and segments of the population with an active role and a broad understanding of the topics of interest of the selected focus group. Each group discussed the important aspects of their topic through a dynamic exchange of ideas among all the participants. The Principal Investigator facilitated each focus group and posed questions from a focus group guide which was comprised of 10 questions, and included the following sections: Demographics, Environmental Influencers, Health Behavior, Health Status, Health Priorities, and Perceived Barriers to Care. Two different guides were used, one for providers and one for non-providers. The focus groups with providers had a few additional questions which were also included

in the discussion. Following the focus group discussion, participants were also asked to complete a short five-question demographic questionnaire and a short-evaluation of the focus group process. Collecting information on the participants needs sought to uncover barriers and limitations, as well as strengths and opportunities within existing healthcare initiatives. Collecting information on the needs of the participant's family's assisted with retrieving data on people that we have not directly reached through survey solicitation. In addition, understanding the needs of the participants' family's also provided insight to any burdens that the participant may be facing as a caregiver.

The following questions were posed by the Focus Group facilitator to **non-Provider participants**:

1. Let's start the discussion by talking about what makes Frederick County a good place to live. What are some of the good things that you enjoy about living here?
2. What are some things that aren't so good about living here in Frederick County?
3. Thinking now about your health, are your health needs being met by county resources and facilities?
    a. If yes, are you satisfied with your care?
    b. If no, what more would you like to see?
4. Thinking now about your family's health, are their health needs being met by county resources and facilities?
    a. If yes, are you satisfied with the care that they are receiving?
    b. If no, what more would you like to see?
5. What are some of the challenges or barriers that you experience when seeking health care?
6. Are there challenges or barriers that you experience that are specific to your race/ethnicity, age, gender, sexual identity, or geographical location?
7. Is there anything else that you would like to share related to health care in Frederick County?

In addition, the following questions also were posed by the Focus Group facilitator to **Provider participants**:

1. Let's start the discussion by talking about what makes Frederick County a good place to live and provide health care. What are some of the good things that you enjoy about working and living here?
2. What are some things that aren't so good about working or living here in Frederick County?
3. Thinking now about the health of your patients, are their health needs being met by county resources and facilities?
    a. If yes in general, do you get the sense that they are satisfied with their care?
    b. If no, what more would you like to see as options for your patients?
4. Now, given the population that you tend to serve, are health care personnel equipped to address the needs of your population? You can consider things like language barriers or cultural competency.
5. Are there services or programs that you would like to see implemented here?
6. What are some of the barriers that your patient population experience when seeking health care?
7. Are there challenges or barriers that your patient population experiences that are specific to their race/ethnicity, age, gender, sexual identity, or geographical location?
    a. Potential follow-up question: Can you think of any solutions that could help address the problem?
8. Is there anything else that you would like to share related to health care in Frederick County?

The focus group conversations resulted in the identification and better understanding of health issues, resources and opportunities within Frederick County residents and providers. The information generated by the discussions will help inform possible solutions and interventions. Please note that this summary report conveys the ideas, concerns, and recommendations of the individuals who attended and participated in the focus group meetings. These comments do not necessarily represent a consensus of any particular group or the position of the Frederick Memorial Hospital, Frederick County Health Department, and The George Washington University Milken Institute School of Public Health. Individuals participating in the focus groups generated the suggestions presented in this report and all suggestions may not be addressed by the Frederick Memorial Hospital and Frederick County Health Department as part of the Frederick County 2015 Needs Assessment report.

MAJOR FINDINGS- Common Themes

Each group identified the most critical issues related to their community of interest. Though discussions focused on a set of given topics, there were some common issues that were identified by many of the groups. At times there was agreement among different focus groups, while in some areas there were conflicts.

The following themes were identified by most of the focus groups:

- Every focus group overwhelmingly enjoyed that the county is rural, but with access to a lot of things, and the close proximity to major metropolitans.
- Most groups noted that for specialty and subspecialty care, they often had to travel outside of Frederick County.
- In terms of health behavior, many residents have seen the same primary care physician for their entire lives. However, there are some residents that utilize the emergency department for pediatric care due to the long wait to see pediatricians in the County. Medical management for the elderly population is also a major issue.
- Many groups noted that they were fortunate to lack huge health needs. However, another group reported individuals experiencing renal failures as a result of poorly managed hypertension and diabetes. Another issue discussed was the high volume of young people and children admitted to the hospital.
- Health priorities discussed by nearly every focus group included increasing resources for mental health, especially for adolescents and young child. Other areas of need included substance abuse, dental care, and management of chronic pain. Another health priority noted was addressing the shortage of primary care physicians in the area.
- Every focus group cited transportation as a perceived barrier to care. Though the county provides a transit service to shuttle patients to and from physicians' appointments, most

groups reported confusion about the registration process or the length of time patients to waited to be picked up after their appointment. Many groups also noted a shortage of primary care providers within the county and a lack of specialists within the county. Another barrier to care is the poorly coordinated Electronic Medical Records system throughout the county and a shortage of foreign language interpreter for patients.

- Several focus groups discussed health insurance as an issue for many residents in Frederick County. This population includes individuals whose household income is too great for eligibility for Medicaid but cannot afford insurance through an employer or the state marketplace. Other issues included lack of awareness of the role of the Frederick County Health Department and the resources it providers and poor communications skills by the providers.
- Some solutions included better communication about the health resources and services available in the county and better coordination among community organizations in disseminating the information. Additionally, they recommended having healthcare providers improve on their communication skills with patients. Focus group participants also spoke of having more stable and affordable housing accommodations for the elderly living alone, low-income families, and homeless.
- In spite of the various barriers to care and health priorities mentioned, many members of the focus groups felt that the County completely met their health needs and would be satisfied with care from fellow providers.

FOCUS GROUP MEETING REPORTS

The following section identifies summaries of each of the six focus group meetings. Each group report includes a table reflecting demographic information of the participants and the organizations they represented. The comments expressed are summarized within the following format:

- Environmental Influencers
- Health Behavior
- Health Status
- Health Priorities
- Perceived Barriers to Care
- Other Important Issues
- Possible solutions to Issues/Problems
- Health Needs Being Met
- Quotes
- Participant Demographic information

SENIOR CITIZENS FOCUS GROUP

Meeting Date: January 5, 2016

Environmental Influencers

- The general consensus of the group was that they enjoyed the ruralness and small town feel of the area, in conjunction with conveniences such as access to healthcare providers. They made note of how family oriented the community was and discussed having deep social connections with their providers.
- However, Frederick County has few specialists, and patients are sometimes required to travel outside of the County for their necessities.
- Some participants recalled noticing community members of lower income in the area living in less than ideal living situations.
- They also noted a changing demographic leading to increased traffic congestion.
- A concern was expressed about the dredging of the Potomac River.

Health Behavior

- Many members of the group have had the same medical provider or group for the majority of their lives and been seen by said provider on a regular basis.

Health Status

- Of their health statuses, the group reported that they were “blessed” to be financially stable, have adequate social support from their friends and families, and have few health needs.

Health Priorities

- Within this group, there were no explicitly mentioned health priorities.

Perceived Barriers to Care

- A barrier to care that was brought up was cost of care for the elderly population.
- Every participant in the group owned a private vehicle, but remarked that they foresaw a day when they would rely more heavily on public transportation. They stated that while public transportation is more prominent in the City of Frederick, there is a lack of it on the outskirts of Frederick County.
- In terms of transportation to and from doctors’ offices, the group mentioned that there was a transit service available. However, it did appear that some members of the group were either not aware of the service and or found the registration process for the service to be confusing. Furthermore, the service does not allow to patrons to schedule an exact pickup time, but asked that they were called after the appointment was over. Thus, many patrons would be left waiting for several hours to be taken home after the appointment.

Other Important Issues

- Another issue that was addressed involved the elderly living alone. While many of the group participants have friends and relative living nearby that would call and check in with them, the group was aware of others who may not have similar social support.
- As anecdotal evidence, they mentioned a particular run-down home off of a main road that they all frequented on a regular basis. This group was uncertain whether or not the older woman living there was still surviving.
- Additionally, they mentioned of lack of County support for low-income families.

Possible solutions to Issues/Problems

- As a possible solution to caring for the elderly that live alone, the group suggested an organization that was County sponsored that called and checked on senior citizens to ensure

that they were well. They made note of a previous County initiative that provided such support and lamented the loss of it.
- In spite of the barrier to care transportation might pose for Frederick residents without a car, positive aspects of the transit service were the affordability of it and that it gave priority to individuals with a doctor's appointment.

Health Needs Being Met

- The group commented on positive relationships with their healthcare providers.
- A participant requiring a particular health need to be met outside of the County did not feel burdened by having to travel to receive it.
- One individual was able to use the transit service provided by the County to attend his doctor's appointments.
- Overall, the group reported that the County was meeting their and their families' health needs.

Quotes

- "There are a lot of people out here that don't have that [access to care for the elderly] and that's one of the things I have against the county."
- "That's the thing about Frederick. It seems like its more family oriented because it's a smaller town."

Participant Demographic information

- This focus group consisted of six participants from Frederick County's older population.
- **Age:** Thirty-three (2) percent were 65-74 years old, 50% (3) were 75-79 years old, and one person over 80 years of age (16.7%).
- **Race:** Sixteen percent (16.7%) of participants identified as Asian/Pacific Islander or Black or African American and 66.7% as White/ Caucasian.
- **Education:** Thirty-three (2) percent reported having some college, with the majority of were college graduates (66.7).
- **Income:** Sixteen percent (16.7%) of individuals had an income level between 0-24K and 25-49K; 33.3% of participants earned between 50-74K and one person (16.7%) 79-99K.
- **Time living in Frederick County:** Over 66% (4) of participants have lived in the county for over 15 years, one person (16.7%) for 5-8 years, and one (16.7%) 10-15 years.

FREDERICK INTEGRATED HEALTH NETWORK (FIHN) BOARD OF DIRECTORS

Meeting Date: January 20, 2016

Environmental Influencers

- Group members enjoyed living in the countryside, while still having access to everything they need as well as family nearby.
- Frederick County is close enough to major universities, including University of Maryland - College Park, that college students are able to commute from home.
- Frederick County is located near major metropolitan areas such as Washington, D.C. and Baltimore. Thus, should residents require care from specialists or subspecialists that are not available in Frederick County, there is still access to them nearby.
- However, within the County, there are also a great number of resources, including those for family, pediatric, and surgical specialties.

Health Behavior

- The participants did not explicitly discuss health behaviors they were actively partaking in during the focus group.

Health Status

- There was no direct mention of their health status among the providers.

Health Priorities

- The group felt that mental health services, including behavioral health, substance abuse, and child and adolescent psychiatric care, are a health priority for the community.
- Another health priority that was discussed was chronic pain management.

Perceived Barriers to Care

- They noted that Frederick Memorial Hospital has a lack in pediatric subspecialties and behavioral health resources.
- Currently, there is no resource to help individuals with chronic pain to navigate and manage their care.
- Transportation for chronic pain patients to their doctors' appointments is challenging because these patients are unable to drive. The County's Transit Service was brought up, along with the difficulties that are involved with setting up the service: filling out forms and taking up the physician's time to see the patient.
- Physicians cited the high deductible plans for some of their patients as barriers to care.
- Furthermore, they remarked there is a need for more practices to accept a greater number of Medicaid patients. There are some medical groups with a cap on accepting patients with Medicaid.
- Dental care was yet another limited resource that was discussed, especially those in need of medical assistance programs.
- The providers stated that geriatric physicians were somewhat limited in the County.
- There are longer wait times for some specialties in the County, including for pulmonology, neurology, GI, and infectious disease.

Other Important Issues

- They mentioned that there are not a large number of activities for young adults to engage in, other than those that would take them into the nearby big cities.
- There is no 24-hour homeless shelter available year-round.
- Though there are a good number of nursing homes in the County, only select ones are covered by insurance.

Possible solutions to Issues/Problems

- Frederick Rescue Mission has a small building for the homeless population.
- Mission of Mercy also provides free dental care.
- The hospital has begun a program to address a segment of the population that has trust issues with big institutions, such as hospitals. This program involves partnering with community organizations to sponsor community health events.

Health Needs Being Met

- Participants believed that the health needs of the family and pediatric population were being met very well.
- Given the smaller size of the County and volume of patients being seen, there is not great need for multiple pediatric subspecialists in the county. However, to address the need that is present, Children's Hospital and Johns Hopkins bring subspecialists into the community on both an occasional and regular basis.
- Additionally, hip surgery, knee surgery, neurosurgery, are all forms of care that are available in the County.
- Rheumatology needs within the County are being met.
- Interpretation services for the deaf community are provided.
- Participants remarked on free health fairs held in Frederick County where blood pressure, diabetes, cholesterol, and hepatitis B and C screenings were offered to meet the needs of Asian and Hispanic populations.
- The participants felt that within the county, there are providers that they would feel comfortable seeing and accessing their health needs from.

Quotes

- "We live out in the country but… [there is] big city stuff if you want to do it.. It's really the best of both worlds from my perspective."
- "We have six [family physicians'] offices scattered around the county…pretty much every little settlement in the county's covered."
- "The only problem we have sometimes with some sub-specialties are things like pediatric endocrine or, or child psychiatry where there's a local, regional, and national shortage."
- "We've entered into this program… where we're working with some faith based organizations and other civic clubs to try to educate some lay health educators to help people in their community learn more about how to self-manage their chronic disease and to help facilitate [fewer] emergency room [visits] because they know where to access resources."

Participant Demographic information

- This focus group was comprised of five medical providers, all who work in Frederick County.

FREDERICK MEMORIAL HOSPITAL LAY HEALTH EDUCATORS FOCUS GROUP

Meeting Date: January 21, 2016

Environmental Influencers

- Many participants appreciate the sense of community, the facilities and many resources available and the close proximity to Baltimore and Washington D.C.
- There is adequate access to services and great interpreter services for members of the deaf and non-English communities in Frederick County.
- The use of the pediatric emergency service due to lack of pediatric general practitioners in the county leads to poor follow up, patients lost in system and returning sick again to the emergency room for services; “It’s a revolving door.”
- Dissatisfaction with surgical outcomes and specialists in Frederick County contributes to residents seeking surgery/treatment outside the county.
- Most participants want to be seen and treated by their primary care physician within Frederick County.
- There exist great resources, especially the hospital, in the county.

Health Behavior

- Medication management is a major issue among the elderly population including getting actual medications filled, taking them properly and understanding prescription.

Health Status

- Several participants disclosed personal health status information about themselves and their families.

Health Priorities

- Major health priorities within Frederick County include: dental care, mental health care, substance abuse, physical health, men’s health, cervical cancer, neurology and support for care givers.
- There is a shortage of primary care physicians, general practitioners for pediatric patients, neurologists and dentists.
- There are many residents who do not have health insurance. This population includes people who make too much to be eligible for Medicaid yet cannot afford regular insurance through the state market place or employer.
- There is a need for provision of quality and improvement in mental, physical health and substance abuse services.
- There is a need for more health advocates/health care navigators for residents to help them navigate through the complex health care system.

Perceived Barriers to Care

- A barrier for members of the deaf community living in Frederick County is the need to make an appointment for an interpreter and inability to have impromptu exchanges with members of the community.
- Some residents of Frederick County are reluctant to access health care due to constantly having to repeat health information to multiple providers because providers of the county are not part of a uniform and coordinated a poorly electronic health system.
- Despite a feeling of “communication overload” where various avenues exist for residents to receive information regarding health and transportation services, there are residents who fail to receive or are simply unaware of this information.
- More must be done to ensure residents who do not have access to certain technologies, like a cell phone or computer and who do not speak English, are receiving health information.

- It is vital to have health professionals who reflect the needs and demographics of residents in order to elicit a level of comfort from residents to inquire about information regarding various health topics.
- Transportation continues to be a major barrier to accessing health services; the transportation to health appointments for the elderly lacks flexibility, is inconvenient and needs to be improved.
- There are interpreters provided with ambulance services for deaf residents during an emergency.
- Long wait time expressed as an issue for some participants, and long wait to see a specialist.
- Rejection of certain insurances by doctor offices within the county force residents to receive care in Gaithersburg, or Rockville for example.

Other Important Issues

- The availability of a new meeting place with fewer restrictions for members of the deaf community to congregate.
- Many health care providers exhibit poor communication skills, do not spend quality time with patients fail to see individual holistically.
- There is confusion among older residents about bringing their primary physicians to Frederick Memorial Hospital and if their primary physicians have privileges there.
- Managing and coordinating one's own health care is the key to ensuring good health since various providers do not communicate between on another effectively.
- Provision of additional resources for care givers as well as support for people who do not have care givers but need assistance.
- There is "infighting" between practices in Frederick County.
- Most participants feel supported in their role of Lay Health workers from various organizations.
- There is a lack of awareness about the Frederick Health Department and services it offers.

Possible solutions to Issues/Problems

- There was a general consensus among participants on the need for organizations to centralize and better coordinate resources, services, and programs to avoid duplication and overlap, while achieving greater effectiveness and efficiency.
- Health providers in general need to improve their communication skills, spend more quality time with their patients to better inform treatment decisions and referrals, and treat patients with greater respect.
- Providing information to older residents on how the health care system and culture has changed and developing ways to better navigate through it.
- A solution to helping older and essentially all patients adapt to more fast paced doctor visits is to educate patients on how to make the most of appointments.
- Strong patient health literacy is important in order to manage own health care; programs are needed to assist residents in managing their health care needs including attending appointments.
- Importance of having a Certified Deaf Interpreter and hearing interpreter to avoid any miscommunication at the hospital or inside an ambulance.
- Pediatric services should be provided within the Frederick Health Department as it once was to provide all residents with pediatric health care services beyond the infant and toddler program.
- To better serve members of the homeless and transient population, shelters offering more stable accommodations and affordable housing should be made available.

Health Needs Being Met

- There was overwhelming group consensus that the health needs of the population they serve are not being met by the resources and facilities that exist in Frederick County, especially in terms of dental care and mental illness care.

Quotes

- "…we have a vibrant…energetic downtown area, and really I think it come backs to really the sense of community and being…one hour from Baltimore and DC."
- "I love that sense of community, I came here and it felt like home."
- "This is one of the top places to live as a deaf…citizen."
- "The hospital community is always there… Frederick Memorial Hospital is the best."
- "I just believe…if there was some centralizing…we would have much more resources than spreading them out against 50 different organizations."
- "We are very behind in Frederick County with the electronic health record [system]."
- "I think a lot of times things are assumed…that people are aware of the resources out there."
- "Frederick Memorial Hospital is doing a great job… many people are comfortable because they can at least have an interpreter, even if they have no family members available, which is really great."
- "Your primary care does not come in, is not able to come in to see you and you're in this hospital and you are lost, and if you're ill, and you can't speak for yourself, anything could happen to you."
- "The transportation is really, really poor here."
- "…there's a lot of resources, but I think that the barrier is the communication is getting that information down at the lowest level."
- "…we need to look at…ambulance services for deaf people. You know, they come pretty quickly, but the interpreters are not provided… Like they're in there, trying to get you on the bed and there's no communication and it's… a very important point …that there's a communication break down at that moment of crisis."
- "It can take months [to see a specialist]."
- "There are not enough female primary care doctors…I want to find another female doctor. Where are they?"
- "...the caregiver is a very important role…and we need to make sure we focus on them."
- "There is a huge shortage of neurologists here in FC...We've been trying to recruit for quite some time now…"
- "I think we need to look at the health department…there are no…medical services for pediatrics, only for immunizations…limited dental…and limited hearing."

Participant Demographic information

- **Age:** Nearly six percent (6.7%) of participants were between the ages of 35-44, 20.3% were 45-54 years old, 33.3% were 55-64 years old, 20% were 65-74 years old and 20% were 75-79 years old.
- **Race:** Thirteen percent (13.3%) of participants identified as Asian/Pacific Islander, 33.3% as Black or African American and 53.3% as White/ Caucasian.
- **Education:** The majority of participants (66.7%) completed graduate school and 26.7% were college graduates; 6.7% completed some graduate school.
- **Income:** Thirteen percent of individuals had an income level between 25-49K; 40% of participants made between 79-99K and 46.7% had an income of 100K or more.
- **Time living in Frederick County:** Over 80% (86.7%) of participants have lived in the county for at least 10 years; 6.7% of individuals have lived in Frederick County for 2 years and 5-8 years respectively.

SPANISH SPEAKING RESIDENTS FOCUS GROUP

Meeting Date: February 13, 2016

Environmental Influencers

- Participants consider Frederick City a small, comfortable community, a good area to raise children, and a sense of companionship and support within the Hispanic community.
- Residents are welcomed to find interpreters.
- Senior citizens find Frederick City to be a wonderful city because they are helped when in need including through provision of transportation services. In fact, Frederick City is becoming a mini cosmopolitan city.
- One participant expressed not experiencing discrimination in Frederick County in contrast to other areas and states.
- There are several excellent community agencies for health and a variety of health professionals.
- The organization of Mission of Nurses is a clinic that offers free medical services and medication for residents who do not have insurance living in Frederick City twice a month.
- Frederick Memorial Hospital has a wonderful perinatal center.
- There are not enough health services for everybody because the community has grown.
- The processes associated with Medicaid and obtaining documents is easier in Frederick City than in Virginia, for example.
- The health department offers a lot of services for children including mental health services, but individuals must have insurance to receive services.

Health Behavior

- Parents take their children to the emergency room for a simple virus, stomachache, or regarding their asthma because they cannot get a soon enough appointment with their pediatrician.

Health Status

- There are individuals who have experienced renal failures as a result of poorly managed high blood pressure and diabetes.
- A number of young people and children were admitted to the hospital.

Health Priorities

- Health priorities include increasing health services in the community and having better communication about and access to these health services.
- There is need for more dental, mental health and ophthalmology services in general in Frederick County.
- Obesity is a health priority.
- More follow up care is needed for individuals with chronic diseases like diabetes and high blood pressure.

Perceived Barriers to Care

- There is lack of transportation.
- The Mission of Mercy doesn’t accept people with insurance including Medicare.
- Few people know about the Mission of Mercy organization due to poor communication.
- There is a high level of low literacy among members of the Hispanic community in Frederick City.

Other Important Issues

- Some participants have experienced negative encounters with health professionals.

- There are people with a job and a home without health insurance who need assistance with medical services.
- An issue exists among individuals whose income barely exceeds the income requirement for Medicaid and yet cannot afford regular insurance.
- There needs to be professionals who provide therapy and/or counseling services in schools that speak Spanish to support children learning English.
- Interpretation services once offered in pediatric offices in the area have been cut off due to financial reasons.
- Members of the Hispanic community have experienced disrespect.
- There are resources available such as Spanish and English language classes, citizenship courses, access to computers, but individuals don't come; they are here to make money.

Possible solutions to Issues/Problems

- There needs to be more communication with and listening to the patient, less assumptions made and more training by health professionals.
- Better communication, beside word of mouth, through various outlets such as the newspaper, is needed to inform community members of health services in the community.
- Bilingual people who speak Spanish and English can be an asset to those in the Hispanic community who struggle with language.

Quotes

- "I love it. I love Frederick."
- "I had my baby and…it's healthy and the attention that I received was wonderful."
- "We need more clinics like Mission of Mercy. We need many, many more services."
- "… communication is probably what we need to inform all the community [of] all the services available in the community."
- "My reasons for coming here because there is more health for the Hispanic community."
- "My son..[is] still a little bit depressed…and I can't find the…mental help [for him]."
- "Right now the most important thing for us is mental health."
- "A lot of children end up coming to the emergency room because they can't get an appointment with their pediatrician…"

Participant Demographic information

- **Age:** In the Centro Hispanic focus group, the percentage of individuals under the 18-24 group was 7.7%, 25-34 group was 15.4%, 35-44 group was 23.1%, 45-54 group was 15.4%, 55-64 group was 30.8%, and among the 75-79 group it was 7.7%.
- **Race:** All participants (100%) identified as Hispanic in regard to race/ethnicity.
- **Education:** Nearly 70% (71.5%) of participants had some college and college graduate level of education; 21.3% of individuals had completed some elementary, some or were high school graduates.
- **Income:** Sixty-three percent of participant's income fell between $0- 24K; 27.3% had an income between $25-49K. Under 10 percent (9.1%) of individuals had an income between $100-124K.
- **Time living in Frederick County:** Fifty-eight percent of individuals lived in Frederick County for 2 years, 8.3% for 5-8 years and 33.3% for 8-10years in the county.

BRUNSWICK PROVIDERS FOCUS GROUP

Meeting Date: February 18, 2016

Environmental Influencers

- This focus group echoed previous focus groups in that its participants enjoyed the small town feel of Frederick County and its accessibility to two major metropolitan areas.
- They remarked that the County truly has everything, from the rural, to the mountains, to the suburbs, to the city.
- Frederick County is located at the junction of West Virginia and Virginia. Thus, patients from those areas are seen in Frederick County as well.
- When asked about disadvantages to living and working in Frederick County, the group could not think of any.

Health Behavior

- Providers reported that the reason why the Jefferson branch office was created was due to the fact that individuals were not willing to drive the extra ten minutes to be seen at the Brunswick medical facility.
- In particular, some members of the elderly population in the community are not willing to go into the city of Frederick if they need to see a specialist. They are more comfortable with seeing a physician in an area that is more rural and less crowded.

Health Status

- None of the providers specifically mentioned to their current health status during the focus group.

Health Priorities

- Providers felt that ancillary health services must be improved within the community, including extended hours for laboratory and radiology services and greater radiology facilities.
- This group of providers also agreed that strengthening mental healthcare was a health priority.
- Lastly, expanding the amount of primary care physicians (PCPs) in the area is significant health priority.

Perceived Barriers to Care

- Ancillary services are somewhat wanting in this community. For example, in order to get an x-ray, patients have to travel to the city of Frederick.
- Due to limited staffing, the practice is unable to keep their in-house laboratory open for extended hours during the week and on Saturdays for those patients who are unable to get laboratory tests performed during the workday.
- They noted that there is a lack of mental health providers, resulting in scheduling challenges and difficulties for mental health patients. They agreed that this is especially true for pediatric patients.
- There is a lack of primary care physicians (PCPs) in the area, as made evident by the typical two to three week backlog for new patient appointments. In fact, one provider who has worked at the practice for several decades noted that s/he is currently being scheduled nine weeks out.
- Beyond the lack of PCPs in the area, participants also reported a lack of medical assistants (MA) for the physicians. This particular practice has only hired one additional MA after advertising for more medical assistant personnel for the past half a year. Their practice still needs at least two more MAs.
- One participant felt that increasing the number of foreign language interpreters would provide higher quality healthcare, including for Vietnamese and Chinese.

- Another barrier to care is transportation, especially for the elderly population. The group noted a medical transportation van that picks patients up for their appointments. Like at other focus groups, they also reported that a limitation to this system was that it does not schedule a pick up time after the appointment and leaves patients waiting for a couple hours to go home.

Other Important Issues

- Communication amongst organizations seems to be somewhat of an issue. This was indicated by the confusion within the group about whether there was a senior center nearby and what activities it provided for seniors.
- The group remarked on the changing demographic of Frederick County and the challenges that could bring in the future.

Possible solutions to Issues/Problems

- In terms of resolving the deficit in PCPs, the group suggested having the community pitch in for the recruitment of more PCPs.

Health Needs Being Met

- There are interpreters available for the deaf community in Frederick County.

Quotes

- But [Frederick] also, where we are at least, has a very nice small town feel so it has kind of the best of both worlds."
- "[I]t's always been kind of friendly, welcoming, and I really do think it has the best of both worlds, I mean… we have this very small town, family practice that we run here and yet we're within an hour of two major metropolitan areas.
- Regarding primary care providers: "We're down from where we have historically been and the area is growing… we need more PCP presence here than we've got right now."
- "I mean our end of the county still has a lot of rural road and populations. It's not like you're on the bus route and you can hop [on] the bus to the pharmacy."

Participant Demographic information

This focus group was conducted among four providers in Brunswick.

- **Age:** In the Brunswick Providers focus group, there were no individuals under the age groups of 18-24, 45-54 and between 65-79 years of age. The percentage of individuals under the age range of 25-34 was 25.0%, under group 35-44 was 50.0% and the age group of 55-64 included 25.0% of individuals.
- **Race:** A quarter of participants stated Asian/Pacific Islander as their race and the remaining 75% of individuals identified as being White/Caucasian.
- **Education:** All participants (100%) completed graduate school.
- **Time living in Frederick County:** One third (33.3%) of participants lived in Frederick County for 2 years, 5-8 years and 15+ respectively.

*Income data was omitted due to privacy and confidentiality concerns of the project team.

HOMELESS INDIVIDUALS FOCUS GROUP

Meeting Date: February 24, 2016

Environmental Influencers

- Participants expressed that the people of Frederick are kind, considerate and generous and you feel safe and secure.
- There are many churches.
- There is a lot of support for people facing different issues.
- Some participants stated it is expensive to live in town.
- On a single person's income, you have to go outside the city to find reasonable housing.
- There exists effective substance abuse rehabilitation centers in Frederick County.
- More and more apartment and condominium buildings are being built that are too expensive for residents to rent or purchase.

Health Behavior

- Most of the participants discussed interactions with their care providers.

Health Status

- It is difficult for some homeless residents to keep a job due to their poor health.
- A lack of housing presents a barrier to improving one's health status.

Health Priorities

- Maintaining sobriety and seeking specialist care was discussed as health priorities.

Perceived Barriers to Care

- Many participants did not face any challenges or barriers to health care related to race, age, gender, or education level.
- Some barriers to good health did include older age, inability to work, experiencing multiple medical needs, and being homeless.
- There is discrimination faced by older and homeless residents as well as people who haven't held a job in a few years when applying for jobs.
- Residents who apply for section 8/affordable housing experience face denial of their application for many reasons and experience persistent rejection after applying many times**.**
- Some participants believe the Section 8 office looks for a reason to deny applicants, making it harder for applicants to be accepted so more people end up giving up.

Other Important Issues

- Multiple participants agree that affordable housing is an important issue.
- Transportation in terms of getting to one's doctor appointment is a problem faced by residents.
- Some participants feel health professionals are not committed to fully helping their patients.
- A major issue some participants face is not having enough money.
- A challenge in the mental health sector is the difficulty for clients to form a lasting connection with their counselor because of the high turnover rate.

Possible solutions to Issues/Problems

- If you are signed up with the FCA, you are provided with transportation to and from your doctor's appointment.

- The best method to get information out about health services could include networking and advertising and in locations such as a church or Frederick Memorial Hospital.

Health Needs Being Met

- Some participants feel that their family's health needs are being met.
- There are case management places all over the area that take good care of clients.
- Participants who have had health coaches and social support from FMH and CORE [community organized recovery effort] are very satisfied with the quality of care, attention and proactive attitude.

Quotes

- "I love the transit service and it's…adequate to get to you where you need to go."
- "I do have a very good doctor in Frederick… and I've been to…Frederick Memorial Hospital and I was taken excellent care."
- "I've gotten this…health coach with FMH [to] help me. She'll even call me out of the blue to check and see how I am…"
- "Problem's no money…that's the biggest problem."
- "But the problem…is…that…just about the time you get comfortable with somebody [a mental health counselor] … they are gone…and that's discouraging."
- "that's an issue that a lot of us we're into…if we had the housing, we could get well."
- "I've got different medical needs…I had been poor all my life ... I've never hit the street till I was 76…you're trying to balance and trying to find something and see if you can move on but there is help… trying to do so much at my age is not easy [to] do…it's juggling, it's hard, but there is help...they are trying to help me."
- "well I think a lot of these [housing] places…you know the harder they make it for you the better they do... because people just end up giving up and we lose hope. They just want you to give up and walk away."

Participant Demographic information

- This focus group consisted of homeless individuals living in Frederick County. Each had lived in Frederick County for a number of years.
- **Age:** In the Brunswick Providers focus group, there were no individuals under the age groups of 18-24, 45-54 and between 65-79 years of age. The percentage of individuals under the age range of 25-34 was 25.0%, under group 35-44 was 50.0% and the age group of 55-64 included 25.0% of individuals.
- **Race:** All participants (100%) identified as being White/Caucasian.
- **Education:** A quarter of participants had some high school education, 25% were high school graduates and 50% had some college level education.
- **Income:** The entire focus group (100%) had an income of 0-24K.
- **Time living in Frederick County:** A quarter of individuals stated to have lived in Frederick County for 5-8 years, 8-10 years, 10-15 years and 15+ respectively.

COMPARISON WITH CENSUS DATA – COUNTY AND STATEWIDE

Comparison with County and Statewide Census Data

We compared the current needs assessment demographic data with census data to assess our sampling and recruitment strategies. In general this sample was similar to the most recent census data. Compared to the most recent census data our sample were a more educated 48.87% vs. 38.2% County and vs. 36.8% statewide with a bachelor's degree or higher (20.6% vs. 14.2%). The recruiting and sampling approach was able to reach a larger number Black/African Americans (21.7% vs. 9.4%) and Hispanic/Latinos (13.1% vs. 8.4% and 9.3 statewide) residents and a lower number of White residents (68.3% vs. 82.8%) compared to the most recent census data. With regard to the income data we collected this information differently, using categories vs. a specific dollar amount. The data show that the sample were grouped in thirds with regard to income. Twenty-eight percent of the sample reported annual incomes of less than $24,999; 30% reported incomes between $25,000 and $74,999 and 35% report incomes of $75,000 or greater; compared to a median income of $84,570 according to the census**.** From these comparisons we can make assumptions about the recruitment strategy and approach and also identify areas to focus on in the future.

Table 11. Comparison with census data – County and Statewide

Category	2015 Frederick Needs Assessment	Most Recent Census Data for Frederick	Most Recent Data for Maryland
Population, 2014 Estimate	---	243,675	5,976,407
Average Age	48.9	--	--
Male	48.6	--	--
Female	48.7	--	--
Education (persons 25+)			
High School Graduate or Higher	90.8%	91.8%[a]	88.7% [a]
Bachelor's Degree or Higher	48.8%	38.2% [a]	36.8% [a]
Race			
White	68.3%	82.8%	60.1%
Black or African American	21.7%	9.4%	30.3%
American Indian/Alaskan Native	0.8%	0.5%	0.6%
Asian (alone)	0.8%	4.5%	6.4%
Native Hawaiian/Pacific Islander	0.2%	0.1%	0.1%
Hispanic/Latino	13.1%	8.4%	9.3%
Home Ownership Rate	53.2%		
Renters	28.9%		
Income	**	$84,570[b]	$73,538[b]
Persons Below Poverty Level	**	6.1%[a]	9.8%[a]
Persons Per Household	0-3	2.69	2.65

[a]2009-2013
[b] Median household income, 2009-2013
Note: Figures in parentheses reflect cumulative percentage (i.e., omitting missing values)

COMPARISON WITH PREVIOUS NEEDS ASSESSMENT

Comparison with Previous Needs Assessment

We compared the current needs assessment with the previous 2013 interim reports to assess changes and gaps and compare sample characteristics. There were some notable differences: the percent obese increased from 24.8% in 2013 to 33.3%. In reported chronic illnesses percentages reporting overweight/obesity was 52.1% in this sample compared to 60.9% in the 2015 Interim Report; High cholesterol was lower 22.2% vs. 36.8%; high blood pressure was higher 30% vs. 27.9% vs. 0.2%; was higher 13.9% vs. 9.3% vs. 0.3%; asthmas was significantly higher 12.4% vs. .049%; and arthritis was lower 17.4% vs. 22.7. Cigarette smoking was lower in the current sample, 14.6% vs. 19.8%. Cancer screenings were similar: mammograms 87.2% vs. 80.0%, pap smear 80% vs. 83.3%; and colonoscopy 58.8% vs. 70%. Health insurance was also compared. Health care coverage was slightly lower 87.4% vs. 92% and lack of insurance coverage 12.6% vs. 9%.

Table 12: Comparisons with Previous Needs Assessments

Health indicators	Category	Frederick County (2015)	Category	Frederick County (FCHD Interim Report Jan 2015)	Category	Frederick County (FMH Community Health Assessment 2013)
(Q 13/ 17/18) BMI Based Obesity Status		33.3%	--	--	Obesity	24.8%
(Q 38) Have you had to go to the emergency room or an urgent care clinic for any illnesses in the last 12 months		27.7%	--	---	Frequency of emergency department visits related to behavioral health	5.02%
(Q 33) Self-reported prevalence of chronic illness						
	Overweight/ obese	52.1%	Overweight/ obese	60.9%	Obesity	24.8%
	High cholesterol	22.2%	High cholesterol	36.8%	Cholesterol	35.5%
	High blood pressure	30.0%	High blood pressure	27.9%	Hypertension	0.2%
	Diabetes	13.9%	Diabetes	9.3%	Diabetes	0.3%
	Asthma	12.4%			Asthma	0.049%
	Arthritis	17.4%	Arthritis	22.7%		
(Q14)Cigarette smoking prevalence		14.6%	Cigarette smoking	19.8%	Adolescent Tobacco use	22.3%
(Q 9/10) Sigmoid colonoscopy (age 50+)		43.8%male/ 58.7% female	--	--	Colonoscopy	70.0%
(Q9) Mammogram in past 2 years (age		75.7%	--	--	Mammogram	80.0%

40+)						
Pap smear (age 18+)		79.1%	--	--	Pap smear	83.3%
(Q 75) Health Insurance Coverage		87.4%	--	--	Have health care coverage?	92.0%
(Q76) Lack of Health Insurance Coverage		12.6%	--	--	Do not have health care coverage	9.0%
(Q32)Not able to access dental care when needed in the past 2 years* *Cost prevented individuals from receiving dental care for themselves or their family the majority of the time		Individual: 28.7% Family: 21.5%	--	--	Childhood Dental visits	55.4%

Bolded Question References refer to questions in the GW Frederick County Needs Assessment Instrument. (2015)

DISCUSSION

The information provided by the needs assessment is to be used to guide further programming, initiatives, and services of the hospital and health department for their residents. The data were able to highlight gaps in care and areas to potentially leverage into additional programs, services, and interventions. Overall the recruitment approach was successful in obtaining a representative sample and the community was vocal and in general was eager to share their health experiences. Future efforts should consider ways to increase yield among home bound residents, the deaf community, and Asian, Pacific Islander, and American Indian individuals.

Next Steps

Overall, eighty-four (84.7%) of the sample reported good or better health. However, 6.4% reported at least one physical limitation. Most were overweight or obese (52.1%). Physical activity (67.5%), weight (65%), and eating properly (61.9%) were the highest rated health priorities. The biggest barriers to care were cost of prescriptions (32.7%), cost/paying co-pays or fees upfront (28.2%), insurance problems (28%), awareness of available services (25.2%), locating the right doctor for health issue (24.9%), not enough time with my doctor (24.5%), employment challenges (22.2%), doctors who do not accept my health insurance (21.1%), and respectful treatment by physician and staff (18.7%). Secondary data analyses were conducted to investigate racial and income based difference, in addition to, ethnicity, education, and insurance status. In summary lower income, lower education, minority, and uninsured residents reported the most barriers, issues with access to care, and mental and physical health problems.

From the focus groups we learned that individuals thoroughly enjoyed living in Frederick County and felt that their health needs were being met, and that there were some common barriers to healthcare and health priorities that were noted. The majority of the groups cited strengthening mental healthcare and addressing the shortage of primary care providers within the county as health priorities. All focus groups discussed transportation as a barrier to care. Some have noticed a shortage of primary care providers and a limited number of specialists practicing in the county. The status of a Frederick County resident's health insurance also affects whether or not care received. Other issues reported by focus groups participants included lack of communication and awareness of the health services and resources available within Frederick County. They felt that better communication and coordination among organizations would help to facilitate improved healthcare for all.

We learned from the structured interviews that most agreed that three of the top health priorities included weight management, eating properly, and cancer prevention. The top three barriers to health care access were transportation, lack of awareness of services, and issues relating to costs, insurance and payment.

Recommendations for Future Needs Assessments

One recommendation for future needs assessment projects would be to hire community residents to work on the needs assessment. This would not only promote the county's commitment to its residents but also strengthen the buy-in from residents regarding the purpose/usefulness of the needs assessment and combating any mistrust between local organizations and the community. Similarly, future efforts should consider convening a community advisory board to help plan and organize recruitment. This board could also serve to promote participation to increase yield.

Another recommendation would be to shorten the survey. Anecdotally, one of the biggest complaints of this process was the length of the survey instrument. While each question provided important information to best serve the county, areas to minimize should be explored.

Future needs assessments should also schedule data collection for warmer months. Outdoor recruitment sites offer the most promise, but recruiting during the fall and winter months has limitations and advantages. Mild temperatures were certainly an advantage but when the temperature turned cooler it appeared to affect participant's likelihood to participate. This is an assumption based on the research team's observations and difficulty recruiting during the colder weather.

When conducting future needs assessments, researchers could assess the feasibility of online surveys, the use of tablets, or other technology for data gathering. The field is moving toward more technological and/or web based survey software which could save both time and money. It can be an affordable option which can be sent out to a large number of people quickly, enabling a wealth of data in a short amount of time. Money is saved on physically publishing and distributing questionnaires. In-person methods require manual data entry, which requires time. It is also prone to data entry errors, which are often mitigated by online survey collection. An online platform guarantees more privacy and anonymity to the respondent, compared to in-person recruitment, where the presence of a researcher may increase interviewer response bias or hesitance to participate and reveal private information. The remote web-based recruitment method requires researchers to have access to email addresses and local newsgroups,[46] which were not available in this needs assessment. If the goal is to identify members of the community, and to identify their needs, these lists may be useful in increasing reach for future recruitment efforts. However, when a

comprehensive list of community members is not available in an underserved or resource-poor community, web based recruitment will undoubtedly miss a crucial segment of the population.

It is also important to note that web-based recruitment requires access to computers, to the internet, and all participants must possess the ability to read and understand directions. Clarification on items may not be possible. Surveying in this manner may miss large subsets of the population, who cannot afford computers, cannot read, or do not have internet access. Thus, the data that is acquired through this recruitment method may not be representative of the population. It may over-represent those with more wealth and affluence, or those who experience drastically different barriers to leading healthy lifestyles. This data may be less generalizable. A hybrid approach which could combine the two approaches where tablets and in-person surveys are used in the field to gather data could increase the number of people reached by the research team. The cost of purchasing the necessary technology should be weighed against the cost of personnel time needed for the standard paper/pencil method.

Limitations

Advantages and Disadvantages of Self-Reported Questionnaire

Self-Reported Questionnaires have many advantages, including low cost to administer, increased participant confidence and honesty when providing responses to questions, and stimulation of participant involvement.[47]

Limitations of a self-reported questionnaire include recall-bias (inability to recall or remember certain occurrences before survey participation), over-reporting, and inaccurate participant interpretation of questions that are different than that of the researcher, therefore providing an inaccurate response and introducing research bias.[47]

Recruitment

There were limitations associated with the selection of residents to complete the needs assessment. Respondents were self-selected and we were only able to reach individuals who visited those establishments during the recruitment events. Another limitation is the potential for social desirability where respondents reply in a manner they believe is wanted or expected. There is also the potential for inaccurate reporting due to mistrust of the process and project team. In an effort to avoid tailored answers, caution was taken during data collection to ensure that the residents knew their responses were going to be completely confidential.

Conclusion

This needs assessment also used an in-person recruitment approach. Overall the recruitment approach was successful in obtaining a representative sample. Research supports tailoring efforts to the specific social determinants of health facilitating or impeding health behaviors in a community (e.g., socioeconomic status). Lastly, it is the recommendation of the team that future efforts incorporate more of the community in the planning and execution of the needs assessment.

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APPENDIX. 1 COMPLETE FINDINGS

Table 13: Recruitment Locations	#
Frederick Memorial Hospital	25
Safeway	23
Westview Promenade	78
Walmart	131
Downtown Frederick	30
YMCA 5k	14
Brunswick	28
Centro Hispano	44
Lutheran Evangelical Church	52
Urbana Senior Citizen Center	9
Dutch's Daughter (Faith STRIDERS)	33
Francis Scott Key Holiday Inn (Fitness Expo)	16
Total	483

Table 14: Cities of Residence Represented in Sample

	#	%
Adamstown	8	1.7
Ballenger Creek	1	.2
Boonsboro	1	.2
Braddock Heights	1	.2
Brunswick	19	3.9
Damascus	1	.2
Daytonabch	1	.2
Frederick	342	70.8
Gainesville	1	.2
Glen Burnie	1	.2
Ijamsville	1	.2
Jefferson	4	.8
Keymar	3	.6
Knoxville	2	.4
Middletown	9	1.9
Monrovia	4	.8
Mount Airy	4	.8
Myersville	4	.8
New Market	21	4.3
Point of Rocks	3	.6
Thurmont	4	.8
Urbana	8	1.7
Walkersville	21	4.3
Woodsboro	2	.4
Missing	17	3.5
Total	483	100.0

Table 15: Participant Demographics

		#	%
Age	18-24	34	7.0
	25-34	72	14.9
	35-44	79	16.4
	45-54	88	18.2
	55-64	87	18.0
	65+	78	16.1
	Missing	45	9.3
Gender identity	Male	143	29.6
	Female	329	68.1
	Transgender/Male/Transman/FTM	0	0
	Transgender/Female/Transwoman/MTF	2	0.4
	Genderqueer	0	0
	Additional category	0	0
	Preferred not to answer	5	1
	Missing	5	1
Marital status	Single	127	26.3
	Married	255	52.8
	Co-habituating/living with a partner	24	5.2
	Separated	17	3.5
	Divorced	34	7
	Widowed	24	5
	Missing	5	1
Sexual orientation	Heterosexual/straight	423	87.6
	Gay or lesbian	3	.6
	Bisexual	10	2.1
	Prefer not to answers	26	5.4
	Missing	21	4.3
Children under 18 in household	0-2	404	83.6
	3-5	47	9.7
	12	1	.2
	Missing	31	6.4
Adults 18 and older in household	0-3	392	81.2
	4-7	48	9.9
	8+	3	0.6
	Missing	40	8.3
Education completed	I never attended school	2	0.4
	Elementary school	7	1.4
	Middle school	6	1.2
	Some high school	29	6
	High school graduate	87	18
	Some college or trade/technical school	114	23.6
	College graduate	127	26.3
	Graduate school	107	22.2
	Missing	4	0.8
Household income	Less than $5,000	36	7.5
	$5,000-$9,999	23	4.8
	$10,000-$14,999	28	5.8
	$15,000-$24,999	50	10.4
	$25,000-$49,999	74	15.3

	$50,000-$74,999	71	14.7
	$75,000-$99,999	65	13.5
	$100,000 or more	104	21.5
	Missing	32	6.6
Health insurance	Yes	411	85.1
	No	59	12.2
	Less than 3 months	8	1.7
	Less than 6 months	6	1.2
	A year or more	11	2.3
	A number of years	14	2.9
	Missing	444	91.9
	Missing	13	2.7
Uninsured in the past 12 months	Yes	66	13.7
	No	396	82.0
	Missing	21	4.3
# who have experienced any of the following in the past 12 months (all that apply)	Transportation problems	39	8.1
	Too long to get an appointment	67	13.9
	Long wait to see doctor or health provider	94	19.5
	Clinic or doctor's office closed upon arrival	19	3.9
	Never had any problems	284	58.8
# of insured children	Yes	265	54.9
	No	88	18.2
	Missing	130	26.9
# of doctor visits in the past 12 months	0	22	4.6
	1-2	169	35
	3-5	143	29.6
	6-10	86	17.8
	10+	55	11.4
	Missing	8	1.7
Employment status (all that apply)	Employed for wages	262	54.2
	Self-employed	49	10.1
	Unemployed	45	9.3
	Out of work for less than one year	13	2.7
	Homemaker	40	8.3
	Student	15	3.1
	Retired	88	18.2
	Unable to work	19	3.9
# of hours of work per week	Less than 10	23	4.8
	10-19	21	4.3
	20-29	33	6.8
	30-39	47	9.7
	40-49	154	31.9
	50+	33	6.8
	I am not currently working	128	26.5
	Missing	44	9.1
# who have personal cell phone	Yes	430	89
	No	40	8.3
	Missing	13	2.7

Housing accommodation	In a home I own	254	52.6
	In a home I rent	138	28.6
	With family	60	12.4
	With a friend	9	1.9
	Homeless in a shelter	5	1.0
	Homeless	11	2.3
	Missing	6	1.2

Table 16: Personal Information			
About the population…		#	%
Years in Frederick County	2 years	62	12.8
	3-5 years	42	8.7
	5-8 years	37	7.7
	8+ years	335	69.4
	Missing	7	1.4
Self-perception of health	Excellent	66	13.7
	Very good	176	36.4
	Good	167	34.6
	Fair	60	12.4
	Poor	10	2.1
	Missing	4	0.8
# who require use of special equipment (e.g., cane, wheelchair, etc.)	Yes	39	8.1
	No	440	91.1
	Missing	4	0.8
# who are blind or vision-impaired	Yes	23	4.8
	No	457	94
	Missing	6	1.2
# who are physically, mentally or emotionally impaired	Yes	31	6.4
	No	440	91.1
	Missing	12	2.5
# who have had a flu shot in the past 12 months	Yes	238	49.3
	No	220	45.5
	Missing	21	4.3
Flu Vaccine locations	Doctor	135	28
	Health department	6	1.2
	Pharmacy	69	14.3
	Health Fair	12	2.5
	Urgent care	3	0.6
	Missing	258	53.4
Reasons for not getting Flu Vaccine	Do not need it	63	13
	Gave me the flu	14	2.9
	Does not work	5	1
	Fear of injection	2	0.4
	Couldn't afford	9	1.9
	Not available	3	0.6
	Not told that I needed it	4	0.8
	Doctor didn't give it to me	5	1
	I am allergic	5	1
	Missing	373	77.2
# tested for HIV	Yes	243	50.3
	No	223	46.2
	Missing	17	3.5
Date of HIV test	A year ago	70	14.5
	2-3 years ago	68	14.1
	More than 5 years	88	18.2
	Missing	257	53.2

# of women who have had:	Mammogram (40+)	137	75.7
	Cervical exam (18+)	216	79.1
	Colonoscopy (50+)	64	58.7
# of men who have had:	Prostate exam (50+)	28	52.8
	Prostate Cancer Screening (PSA) (50+)	19	38.8
	Colonoscopy (50+)	21	43.8

Table 17: Health Behaviors

		#	%
# of servings of fruits and vegetables per day	0	16	3.3
	1-2	195	40.4
	3-4	187	38.7
	5 or more	73	15.1
	Don't know	7	1.4
	Missing	5	1
Reasons of not taking enough servings of fruits and vegetables	Don't like the taste	1	0.2
	Costs too much	9	1.9
	No good selection	1	0.2
	Never think about it	10	2.1
	Missing	462	95.7
# who exercise minutes per day	None	44	9.1
	Very little (less than 10m)	92	19
	Some (approx. 15m)	136	28.2
	About what's recommended	122	25.3
	A lot (more than 40m)	82	17
	Don't know	3	0.6
	Missing	4	0.8
Reasons for not getting enough exercise	I don't enjoy it	5	1
	Too busy/no time	19	3.9
	Cost too much	2	0.4
	Have physical problems	8	1.7
	I Lack motivation	9	1.9
	I never think about it	2	0.4
	Missing	438	90.7
Perception of healthy weight	Yes	221	45.8
	No	234	48.4
	Don't know	25	5.2
	Missing	3	0.6
BMI (Body Mass Index) Category	Underweight	4	.8
	Normal Weight	95	19.7
	Overweight	91	18.8
	Obese	161	33.3
	Missing	132	27.3
Smoking status	Yes	70	14.5
	No	407	84.3
	Don't know	2	0.4
	Missing	4	0.8

# who have a doctor for regular check-ups	Yes	397	82.2
	No	81	16.8
	Don't know	2	0.4
	Missing	3	0.6
# who take doctor prescribed medication	Yes	408	84.5
	No	84.5	12
	Don't know	6	1.2
	Missing	11	2.3
Reasons for not talking all prescribed medications	Couldn't afford it	3	0.6
	I don't think I needed it	5	1
	Missing	475	98.3
Hispanic or Latino	Yes	61	12.6
	No	401	83
	Don't know	2	0.4
	Missing	19	3.9
Languages spoken at home	English	444	91.9
	Spanish	64	13.3
	Chinese	1	0.2
	Tagalog	2	0.4
	Vietnamese	0	0
	French	5	1
	American Sign Language	11	2.3
	German	2	0.4
	Korean	1	0.2
	Arabic	0	0
	Russian	1	0.2
	Italian	1	0.2
	Other	0	0
	Missing	3	0.6
Racial Identity	White	327	67.7
	Black or African American	120	24.8
	Asian	16	3.3
	Native Hawaiian or Other Pacific Islander	2	0.4
	American Indian, Alaska Native	12	2.5
	Other	0	0
	Don't know	10	2.1
	Missing	11	2.3
# who speak English well	Very well	417	86.3
	Well	33	6.8
	Not very well	19	3.9
	Not at all	9	1.9
	Missing	5	1
# who clearly understands doctor's instructions and directions	Yes	446	92.3
	No	27	5.6
	Missing	10	2.1
Frequency of provision of interpretation/translation services	Always	25	5.2
	Sometimes	16	3.3
	Rarely	14	2.9

	Never	366	75.8
	Missing	62	12.8
# who read English well	Very well	421	87.2
	Well	33	6.8
	Not very well	12	2.5
	Not at all	11	2.3
	Missing	6	1.2
# who read well in their own language	Very well	426	88.2
	Well	26	5.4
	Not very well	6	1.2
	Not at all	2	0.4
	Missing	23	4.8
# of doctors who give written instructions or discharge summary in preferred language	Always	368	76.2
	Sometimes	48	9.9
	Never	52	10.8
	Missing	15	3.1

Table 18: Family Life

How often do you worry about the following:		#	%
Safety	All of the time	117	24.2
	Most of the time	67	13.9
	Some of the time	122	25.3
	A little of the time	96	19.9
	None of the time	65	13.5
	Missing	16	3.3
Finances (Money)	All of the time	147	30.4
	Most of the time	90	18.6
	Some of the time	108	22.4
	A little of the time	75	15.5
	None of the time	47	9.7
	Missing	16	3.3
Housing payments	All of the time	103	21.3
	Most of the time	77	15.9
	Some of the time	70	14.5
	A little of the time	60	12.4
	None of the time	154	31.9
	Missing	19	3.9
Affording healthy meals	All of the time	89	18.4
	Most of the time	56	11.6
	Some of the time	81	16.8
	A little of the time	68	14.1
	None of the time	161	33.3
	Missing	28	5.8
Paying for personal medication costs	All of the time	86	17.8
	Most of the time	47	9.7
	Some of the time	85	17.6
	A little of the time	74	15.3
	None of the time	173	35.8
	Missing	18	3.7
Paying for medication costs for people in my care	All of the time	72	14.9

	Most of the time	36	7.5
	Some of the time	75	15.5
	A little of the time	66	13.7
	None of the time	194	40.2
	Missing	40	8.3
Caring for my family in the event of an emergency	All of the time	119	24.6
	Most of the time	61	12.6
	Some of the time	101	20.9
	A little of the time	79	16.4
	None of the time	100	20.7
	Missing	23	4.8
Job security	All of the time	87	18
	Most of the time	57	11.8
	Some of the time	89	18.4
	A little of the time	60	12.4
	None of the time	149	30.8
	Missing	41	8.5
How often has cost prevented you from doing the following:			
Getting health care for yourself when needed	All of the time	56	11.6
	Most of the time	40	8.3
	Some of the time	74	15.3
	A little of the time	59	12.2
	None of the time	244	50.5
	Missing	10	2.1
Getting dental care for yourself when needed	All of the time	79	16.4
	Most of the time	56	11.6
	Some of the time	66	13.7
	A little of the time	55	11.4
	None of the time	213	44.1
	Missing	14	2.9
Getting health care for a family member	All of the time	51	10.6
	Most of the time	32	6.6
	Some of the time	52	10.8
	A little of the time	55	11.4
	None of the time	273	56.5
	Missing	20	4.1
Getting dental care for a family member	All of the time	64	13.3
	Most of the time	35	7.2
	Some of the time	59	12.2
	A little of the time	40	8.3
	None of the time	262	54.2
	Missing	23	4.8
Paying for medication for myself	All of the time	63	13
	Most of the time	37	7.7
	Some of the time	57	11.8
	A little of the time	59	12.2
	None of the time	249	51.6
	Missing	18	3.7
Paying for medication for a family member	All of the time	50	10.4
	Most of the time	34	7
	Some of the time	46	9.5

	A little of the time	57	11.8
	None of the time	270	55.9
	Missing	26	5.4

Table 19: Chronic disease or condition

	#	%
Alcoholism/Drinking/Drug Abuse	31	6.4
Allergies	123	25.5
Alzheimer's	3	0.6
Anxiety	96	19.9
Arthritis	84	17.4
Asthma/Bronchitis/Emphysema	60	12.4
Autoimmune Disease	19	3.9
Cancer	48	9.9
Depression	91	18.8
Diabetes (Sugar)	67	13.9
Epilepsy/Seizures	8	1.7
Gastrointestinal Disease	36	7.5
Glaucoma	14	2.9
Headaches/Migraines	79	16.4
Heart Disease/Heart Attack/Heart Failure	29	6
High Blood Pressure	145	30
High Cholesterol	107	22.2
HIV/Aids	1	0.2
Kidney Disease	6	1.2
Mental Illness	24	5
Pain	74	15.3
Prostate Problems	12	2.5
Sexual Problems	14	2.9
Stress	83	17.2
Stroke	8	1.7
Thyroid Disease	51	10.6
Vascular Disease	3	0.6
Missing	69	14.3

Table 20: Health Information Seeking Sources

	#	%
Brochures	150	31.1
Newspapers	88	18.2
Health Magazines	87	18
Television	58	12
Classes	49	10.1
Videos	29	6
Internet	260	53.8
Healthcare provider	318	65.8
Family or Friend	109	22.6
Health Department	51	10.6
Don't know	15	3.1
Missing	10	2.1

Table 21: Biggest Health Concerns		n	%
# who are getting help for health concern	Yes	286	59.2
	No	126	26.1
	Don't know	27	5.6
	Missing	44	9.1
# who receive health care in Frederick County	Yes	388	80.3
	No	81	16.8
	Don't know	4	0.8
	Missing	10	2.1
# who have gone to the emergency room or urgent care clinic in the past 12 months	Yes	131	27.1
	No	341	70.6
	Don't know	1	0.2
	Missing	10	2.1
# who would use services for a health need if available in Frederick County	Yes	339	70.2
	No	47	9.7
	Don't know	25	5.2
	I already receive my care from county resources	47	9.7
	Missing	25	5.2

Table 22: Services that respondent would be interested in if available		
	#	%
Alcoholism/Drug Abuse Counseling	29	6
Chronic Disease Support Groups	31	6.4
Family Counseling	73	15.1
Marriage/Couples Counseling	67	13.9
Weight Loss Programs	169	35
Exercise Programs	206	42.7
Personal Money Management/Family Budgeting	108	22.4
Elderly Ageing	64	13.3
Healthy Eating Cooking Classes	169	35
Mental Health Counseling	66	13.7
Diabetes (Sugar) Monitoring	75	15.5
Primary Care Services (Visit with nurse of doctor)	98	20.3
Cancer screening and education classes	62	12.8
Dental services	149	30.8
Family Planning	51	10.6
LGBTQ	7	1.4
Missing	91	18.8

Table 23: Households members diagnosed with the following chronic diseases						
Disease/Condition	Self	Spouse/P	Child	Parent	Other	Is person getting help for condition?

		artner						
	N (%)	N (%)	N (%)	N (%)	N (%)	Yes	No	Missing
Alcoholism/Drinking/Drug Abuse	7(1.4)	13 (2.7)	7 (1.4)	13 (2.7)	10 (2.1)	14 (2.9)	16 (3.3)	453 (93.6)
Allergies	22 (4.6)	29 (6)	47 (9.7)	19 (3.9)	12 (2.5)	63 (13)	10 (2.1)	410 (84.9)
Alzheimer's	0	3 (0.6)	1 (0.2)	10 (2.1)	1 (0.2)	10 (2.1)	3 (0.6)	470 (97.3)
Anxiety	12 (2.5)	27 (5.6)	17 (3.5)	19 (3.9)	8 (1.7)	42 (8.7)	11 (2.3)	430 (89)
Arthritis	19 (3.9)	21 (4.3)	2 (0.4)	23 (4.8)	9 (1.9)	42 (8.7)	5 (1)	436 (90.3)
Asthma/Bronchitis/Emphysema	12 (2.5)	14 (2.9)	32 (6.6)	14 (2.9)	12 (2.5)	42 (8.7)	8 (1.7)	433 (89.6)
Auto-immune disease	4 (0.6)	6 (1.2)	2 (0.4)	4 (0.8)	2 (0.4)	10(2.1)	2 (0.4)	471 (97.5)
Cancer	11 (2.3)	20 (4.1)	9 (1.9)	20 (4.1)	10 (2.1)	30 (6.2)	3 (0.6)	450 (93.2)
Depression	13 (2.7)	19 (3.9)	19 (3.9)	15 (3.1)	8 (1.7)	31 (6.4)	12 (2.5)	440 (91.1)
Diabetes	15 (3.1)	30 (6.2)	6 (1.2)	26 (5.4)	16 (3.3)	52(10.8)	3 (0.6)	428 (88.6)
Developmental disabilities	0	1 (0.2)	5 (1)	1 (0.2)	1 (0.2)	4 (0.8)	2 (0.4)	477 (98.8)
Epilepsy/seizures	4 (0.8)	3 (0.6)	3 (0.6)	1 (0.2)	6 (1.2)	8 (1.7)	2 (0.4)	473 (97.9)
Gastrointestinal disease	7 (1.4)	6 (1.2)	4 (0.8)	6 (1.2)	6 (1.2)	12 (2.5)	3 (0.6)	468 (96.9)
Glaucoma	4 (0.8)	4 (0.8)	0	5 (1)	2 (0.4)	5 (1)	1 (0.2)	477 (98.8)
Gout	1 (0.2)	7 (1.4)	1 (0.2)	5 (1)	3 (0.6)	6 (1.2)	2 (0.4)	475 (98.3)
Headache/migraines	7 (1.4)	9 (1.9)	6 (1.2)	13 (2.7)	11 (2.3)	17 (3.5)	11 (2.3)	455 (94.2)
Heart disease/heart attack/heart failure	6 (1.2)	21 (4.3)	4 (0.8)	22 (4.6)	5 (1)	26 (5.4)	2 (0.4)	455 (94.2)
High blood pressure	34 (7)	68 (14.1)	3 (0.6)	38 (7.9)	14 (2.9)	79 (16.4)	3 (0.6)	401 (83)
High cholesterol	23 (4.8)	43 (8.9)	1 (2)	25 (5.2)	14 (2.9)	58 (12)	4 (0.8)	421 (87.2)
HIV/AIDS	1 (0.2)	0	0	0	1 (0.2)	2 (0.4)	1 (0.2)	480 (99.4)
Kidney disease	2 (0.4)	12 (2.5)	0	1 (0.2)	0	6 (1.2)	1 (0.2)	476 (98.6)
Mental illness	2 (0.4)	8 (1.7)	8 (1.7)	4 (0.8)	3 (0.6)	10 (2.1)	3 (0.6)	470 (97.3)
Pain	10 (2.1)	14 (2.9)	4 (0.8)	14 (2.9)	5 (1)	19 (3.9)	7 (1.4)	457 (94.6)
Prostrate problems	3 (0.6)	17 (3.5)	0	2 (0.4)	2 (0.4)	8 (1.7)	2 (0.40	473 (97.9)
Sexual problems	1 (0.2)	6 (1.2)	0	0	3 (0.6)	2 (0.4)	2 (0.40	479 (99.2)
Stress	6 (1.2)	10 (2.1)	1 (0.2)	16 (3.3)	5 (1)	11 (2.3)	10 (2.1)	462 (95.7)
Stroke	1 (0.2)	4 (0.8)	1 (0.2)	8 (1.7)	2 (0.4)	7 (1.4)	1 (0.2)	475 (98.3)
Thyroid disease	12 (2.5)	9 (1.9)	3 (0.6)	11 (2.3)	6 (1.2)	25 (5.2)	2 (0.4)	456 (94.4)
Vascular disease	2 (0.4)	5 (1)	0	1 (0.2)	0	4 (0.8)	2 (0.4)	477 (98.8)

Table 24: Children's Health		
Health Have your children had any of the following health concerns:	#	%
I do not have any children	99	20.5
Asthma	63	13
Diabetes	21	4.3
Developmental disability	10	2.1
Physical disability	8	1.7
Mental/intellectual disability	13	2.7
Mental illness	23	4.8
Weight problems	51	10.6
Nutrition problems	11	2.3
Alcohol/drug use or abuse	10	2.1
Behavioral problems	23	4.8
Cancer	6	1.2
Overall poor physical health	7	1.4
Sleep problems	22	4.6
Child worries a lot	33	6.8

Table 25: Family Health Care		#	%
# of families who receive health care in Frederick County	Yes	353	73.1
	No	86	17.8

	Don't Know	14	2.9
	Missing	28	5.8

Table 26. Physical and mental health during past 30 days

		#	%
Pain prevents usual activities	All the time	25	5.2
	Most of the time	36	7.5
	Some of the time	69	14.3
	A little of the time	78	16.1
	None of the time	239	49.5
	Missing	36	7.5
Sad or Depressed	All the time	18	3.7
	Most of the time	34	7
	Some of the time	56	11.6
	A little of the time	113	23.4
	None of the time	220	45.5
	Missing	42	8.7
Worried or Tense	All the time	27	5.6
	Most of the time	41	8.5
	Some of the time	97	20.1
	A little of the time	118	24.4
	None of the time	162	33.5
	Missing	38	7.9
Healthy/Energetic	All the time	30	6.2
	Most of the time	155	32.1
	Some of the time	99	20.5
	A little of the time	69	14.3
	None of the time	83	17.2
	Missing	47	9.7
Nervous	All the time	22	4.6
	Most of the time	32	6.6
	Some of the time	73	15.1
	A little of the time	103	21.3
	None of the time	204	42.2
	Missing	49	10.1
Hopeless	All the time	16	3.3
	Most of the time	22	4.6
	Some of the time	39	8.1
	A little of the time	64	13.3
	None of the time	295	61.1
	Missing	47	97

Restless	All the time	21	4.3
	Most of the time	21	4.3
	Some of the time	56	11.6
	A little of the time	83	17.2
	None of the time	253	52.4
	Missing	49	10.1
So depressed could not be cheered up	All the time	16	3.3
	Most of the time	12	2.5
	Some of the time	34	7
	A little of the time	47	9.7
	None of the time	325	67.3
	Missing	49	10.1
Everything was an effort	All the time	24	5
	Most of the time	24	5
	Some of the time	42	8.7
	A little of the time	63	13
	None of the time	280	58
	Missing	50	10.4
Worthless	All the time	16	3.3
	Most of the time	11	2.3
	Some of the time	30	6.2
	A little of the time	44	9.1
	None of the time	324	67.1
	Missing	58	12
Mental Health condition that prevents usual activities	All the time	18	3.7
	Most of the time	18	3.7
	Some of the time	27	5.6
	A little of the time	42	8.7
	None of the time	322	66.7
	Missing	56	11.6
# who visited doctor about any of the aforementioned symptoms	Yes	142	29.4
	No	233	48.2
	Don't Know	11	2.3
	Missing	97	20.1

Table 27. Self-report of personal health problems and priorities

		#	%

Personal health is no better or worse than others	Strongly agree	58	12
	Agree	156	32.3
	Neutral	153	31.7
	Disagree	88	18.2
	Strongly disagree	16	3.3
	Missing	12	2.5
Available services are available to address personal needs	Strongly agree	72	14.9
	Agree	197	40.8
	Neutral	123	25.5
	Disagree	54	11.2
	Strongly disagree	22	4.6
	Missing	15	3.1
Health Department services are relevant to personal needs	Strongly agree	56	11.6
	Agree	188	38.9
	Neutral	161	33.3
	Disagree	39	8.1
	Strongly disagree	18	3.7
	Missing	21	4.3
I have access to needed programs and services	Strongly agree	80	16.6
	Agree	205	42.4
	Neutral	106	21.9
	Disagree	53	11
	Strongly disagree	17	3.5
	Missing	22	4.6
I have unique health needs	Strongly agree	30	6.2
	Agree	52	10.8
	Neutral	107	22.2
	Disagree	103	21.3
	Strongly disagree	163	33.7
	Missing	28	5.8

Table 28: Personal Health Priorities

		#	%
Weight	Strongly agree	156	32.3
	Agree	158	32.7
	Neutral	50	10.4
	Disagree	53	11
	Strongly disagree	50	10.4
	Missing	16	3.3

Physical activity	Strongly agree	152	31.5

	Agree	174	36
	Neutral	68	14.1
	Disagree	32	6.6
	Strongly disagree	28	5.8
	Missing	29	6
Cardiovascular disease	Strongly agree	79	16.4
	Agree	122	25.3
	Neutral	95	19.7
	Disagree	64	13.3
	Strongly disagree	62	12.8
	Missing	61	12.6
Diabetes	Strongly agree	75	15.5
	Agree	103	21.3
	Neutral	108	22.4
	Disagree	67	13.9
	Strongly disagree	74	15.3
	Missing	56	11.6
Eating properly	Strongly agree	133	27.5
	Agree	166	34.4
	Neutral	71	14.7
	Disagree	34	7
	Strongly disagree	37	7.7
	Missing	42	8.7
Sexual and reproductive health	Strongly agree	61	12.6
	Agree	90	18.6
	Neutral	140	29
	Disagree	57	11.8
	Strongly disagree	72	14.9
	Missing	63	13
Mental health	Strongly agree	88	18.2
	Agree	92	19
	Neutral	111	23
	Disagree	50	10.4
	Strongly disagree	78	16.1
	Missing	64	13.3
Alcohol/drug use or abuse	Strongly agree	32	6.6
	Agree	57	11.8
	Neutral	105	21.7
	Disagree	69	14.3
	Strongly disagree	151	31.3
	Missing	69	14.3

Oral health	Strongly agree	104	21.5
	Agree	137	28.4
	Neutral	77	15.9
	Disagree	37	7.7
	Strongly disagree	59	12.2
	Missing	69	14.3
Cancer prevention/treatment	Strongly agree	80	16.6
	Agree	105	21.7
	Neutral	99	20.5
	Disagree	50	10.4
	Strongly disagree	75	15.5
	Missing	74	15.3
Sexually transmitted diseases/infection	Strongly agree	45	9.3
	Agree	47	9.7
	Neutral	102	21.1
	Disagree	73	15.1
	Strongly disagree	144	29.8
	Missing	72	14.9
Injuries	Strongly agree	65	13.5
	Agree	82	17
	Neutral	103	21.3
	Disagree	54	11.2
	Strongly disagree	113	23.4
	Missing	66	13.7
Smoking cessation	Strongly agree	38	7.9
	Agree	37	7.7
	Neutral	97	20.1
	Disagree	60	12.4
	Strongly disagree	180	37.3
	Missing	71	14.7
Asthma/Respiratory Problems	Strongly agree	42	8.7
	Agree	72	14.9
	Neutral	106	21.9
	Disagree	65	13.5
	Strongly disagree	132	27.3
	Missing	66	13.7

Table 29: Personal Barriers to Obtaining Health Care

		#	%

Transportation	Strongly agree	38	7.9
	Agree	33	6.8
	Neutral	71	14.7
	Disagree	83	17.2
	Strongly disagree	220	45.5
	Missing	38	7.9
Insurance Problems	Strongly agree	69	14.3
	Agree	66	13.7
	Neutral	69	14.3
	Disagree	79	16.4
	Strongly disagree	166	34.4
	Missing	34	7
Employment Challenges	Strongly agree	52	10.8
	Agree	55	11.4
	Neutral	90	18.6
	Disagree	68	14.1
	Strongly disagree	176	36.4
	Missing	42	8.7
Child Care	Strongly agree	31	6.4
	Agree	37	7.7
	Neutral	91	18.8
	Disagree	67	13.9
	Strongly disagree	212	43.9
	Missing	45	9.3
Awareness of Available Services	Strongly agree	49	10.1
	Agree	73	15.1
	Neutral	100	20.7
	Disagree	59	12.2
	Strongly disagree	154	31.9
	Missing	48	9.9
Mistrust of Program and Services	Strongly agree	27	5.6
	Agree	43	8.9
	Neutral	108	22.4
	Disagree	78	16.1
	Strongly disagree	177	36.6
	Missing	50	10.4
Language/Translation Concerns	Strongly agree	29	6.0
	Agree	22	4.6
	Neutral	73	15.1
	Disagree	67	13.9
	Strongly disagree	250	51.8

	Missing	42	8.7
Access to printed material and doctor's instructions in my language	Strongly agree	22	4.6
	Agree	25	5.2
	Neutral	85	17.6
	Disagree	68	14.1
	Strongly disagree	241	49.9
	Missing	42	8.7
Cost/paying co-pays or fees upfront	Strongly agree	67	13.9
	Agree	69	14.3
	Neutral	86	17.8
	Disagree	59	12.2
	Strongly disagree	163	33.7
	Missing	39	8.1
Understanding the words and concepts doctor uses	Strongly agree	27	5.6
	Agree	30	6.2
	Neutral	86	17.8
	Disagree	80	16.6
	Strongly disagree	214	44.3
	Missing	46	9.5
Doctors who do not accept my health insurances	Strongly agree	47	9.7
	Agree	55	11.4
	Neutral	93	19.3
	Disagree	74	15.3
	Strongly disagree	165	34.2
	Missing	49	10.1
Not enough time with my doctor	Strongly agree	39	8.1
	Agree	79	16.4
	Neutral	94	19.5
	Disagree	72	14.9
	Strongly disagree	159	32.9
	Missing	40	8.3
Locating the right doctor for issue	Strongly agree	50	10.4
	Agree	70	14.5
	Neutral	91	18.8
	Disagree	70	14.5
	Strongly disagree	162	33.5
	Missing	40	8.3
Respectful treatment physician or staff	Strongly agree	38	7.9
	Agree	52	10.8
	Neutral	89	18.4

	Disagree	87	18
	Strongly disagree	173	35.8
	Missing	44	9.1
Culturally and faith sensitive physician	Strongly agree	22	4.6
	Agree	24	5
	Neutral	103	21.3
	Disagree	73	15.1
	Strongly disagree	216	44.7
	Missing	45	9.3
Cost of prescriptions	Strongly agree	80	16.6
	Agree	78	16.1
	Neutral	79	16.4
	Disagree	62	12.8
	Strongly disagree	140	29
	Missing	44	9.1

Table 30. Perceptions of county health problems and priorities

		#	%
County Health is worse than others	Strongly agree	19	3.9
	Agree	40	8.3
	Neutral	223	46.2
	Disagree	133	27.5
	Strongly disagree	51	10.6
	Missing	17	3.5
Available services are adequate to county's needs	Strongly agree	34	7
	Agree	145	30
	Neutral	183	37.9
	Disagree	75	15.5
	Strongly disagree	26	5.4
	Missing	20	4.1
Health Department services are relevant to county needs	Strongly agree	32	6.6
	Agree	156	32.3
	Neutral	186	38.5
	Disagree	67	13.9
	Strongly disagree	25	5.2
	Missing	17	3.5
Residents have access to needed programs and services	Strongly agree	35	7.2
	Agree	164	34
	Neutral	169	35
	Disagree	76	15.7
	Strongly disagree	24	5
	Missing	15	3.1

Frederick County has unique health needs	Strongly agree	22	4.6
	Agree	52	10.8
	Neutral	237	49.1
	Disagree	101	20.9
	Strongly disagree	41	8.5
	Missing	30	6.2
Perceptions of Frederick County Health Priorities			
		#	%
Weight	Strongly agree	151	31.3
	Agree	189	39.1
	Neutral	97	20.1
	Disagree	19	3.9
	Strongly disagree	10	2.1
	Missing	17	3.5
Physical activity	Strongly agree	128	26.5
	Agree	183	37.9
	Neutral	116	24
	Disagree	24	5
	Strongly disagree	6	1.2
	Missing	26	5.4
Cardiovascular disease	Strongly agree	105	21.7
	Agree	154	31.9
	Neutral	160	33.1
	Disagree	21	4.3
	Strongly disagree	10	2.1
	Missing	33	6.8
Eating properly	Strongly agree	111	23
	Agree	182	37.7
	Neutral	125	25.9
	Disagree	26	5.4
	Strongly disagree	11	2.3
	Missing	28	5.8
Sexual and Reproductive Health	Strongly agree	69	14.3
	Agree	107	22.2
	Neutral	227	47
	Disagree	23	4.8
	Strongly disagree	20	4.1
	Missing	37	7.7
Mental Health	Strongly agree	104	21.5
	Agree	153	31.7

	Neutral	143	29.6
	Disagree	26	5.4
	Strongly disagree	17	3.5
	Missing	40	8.3
Drug Use/Abuse	Strongly agree	122	25.3
	Agree	151	31.3
	Neutral	132	27.3
	Disagree	24	5
	Strongly disagree	19	3.9
	Missing	35	7.2
Oral Health	Strongly agree	83	17.2
	Agree	147	30.4
	Neutral	171	35.4
	Disagree	28	5.8
	Strongly disagree	16	3.3
	Missing	38	79
Cancer Prevention/Treatment	Strongly Agree	98	20.3
	Agree	148	30.6
	Neutral	158	32.7
	Disagree	20	4.1
	Strongly disagree	12	2.5
	Missing	47	9.7
Sexually Transmitted Diseases/Infection	Strongly agree	73	15.1
	Agree	131	27.1
	Neutral	194	40.2
	Disagree	23	4.8
	Strongly disagree	21	4.3
	Missing	41	8.5
Injuries	Strongly agree	72	14.9
	Agree	127	26.3
	Neutral	192	39.8
	Disagree	27	5.6
	Strongly disagree	13	2.7
	Missing	52	10.8
Smoking Cessation	Strongly agree	92	19
	Agree	145	30
	Neutral	163	33.7
	Disagree	21	4.3
	Strongly disagree	19	3.9
	Missing	43	8.9
Asthma/Respiratory Problems	Strongly agree	80	16.6
	Agree	121	25.1

	Neutral	200	41.4
	Disagree	25	5.2
	Strongly disagree	15	3.1
	Missing	42	8.7
Diabetes	Strongly agree	100	20.7
	Agree	156	32.3
	Neutral	152	31.5
	Disagree	18	3.7
	Strongly disagree	17	3.5
	Missing	40	8.3

Table 31: Perceptions of Frederick County Barriers to Obtaining Health Care

		#	%
Transportation	Strongly agree	108	22.4
	Agree	146	30.2
	Neutral	137	28.4
	Disagree	29	6
	Strongly disagree	30	6.2
	Missing	33	6.8
Insurance Status	Strongly agree	149	30.8
	Agree	140	29
	Neutral	121	25.1
	Disagree	20	4.1
	Strongly disagree	25	5.2
	Missing	28	5.8
Employment Challenges	Strongly agree	120	24.8
	Agree	137	28.4
	Neutral	152	31.5
	Disagree	20	4.1
	Strongly disagree	23	4.8
	Missing	31	6.4
Child Care	Strongly agree	120	24.8
	Agree	132	27.3
	Neutral	150	31.1
	Disagree	23	4.8
	Strongly disagree	25	5.2
	Missing	33	6.8
Awareness of Available Services	Strongly agree	121	25.1
	Agree	139	28.8

	Neutral	144	29.8
	Disagree	18	3.7
	Strongly disagree	24	5
	Missing	37	7.7
Mistrust of Program and Services	Strongly agree	80	16.6
	Agree	118	24.4
	Neutral	190	39.3
	Disagree	35	7.2
	Strongly disagree	26	5.4
	Missing	34	7
Understanding the words and concepts doctor uses	Strongly agree	77	15.9
	Agree	107	22.2
	Neutral	195	40.4
	Disagree	40	8.3
	Strongly disagree	26	5.4
	Missing	38	7.9
Access to printed materials and doctor's instructions in person's language; availability of interpreter	Strongly agree	78	16.1
	Agree	93	19.3
	Neutral	200	41.4
	Disagree	48	9.9
	Strongly disagree	34	7
	Missing	30	6.2
Support of culture's practices and beliefs	Strongly agree	74	15.3
	Agree	84	17.4
	Neutral	215	44.5
	Disagree	44	9.1
	Strongly disagree	32	6.6
	Missing	34	7
Cost of obtaining prescriptions	Strongly agree	142	29.4
	Agree	130	26.9
	Neutral	145	30
	Disagree	15	3.1
	Strongly disagree	23	4.8
	Missing	28	5.8

Table 32. Awareness of Frederick County community engagement

		#	%

Do you think that other organizations in the community try to help you be a healthier person?	Yes	285	59
	No	72	14.9
	Not sure	116	24
	Missing	10	2.1
# who have attended events	Yes	149	30.8
	No	305	63.1
	Missing	29	6
# who are members of these organizations	Yes	85	17.6
	No	358	74.1
	Missing	40	8.3

Table 33: Perceptions of Frederick County Barriers to Obtaining Health Care

		#	%
Transportation	Strongly agree	100	20.7
	Agree	156	32.3
	Neutral	152	31.5
	Disagree	18	3.7
	Strongly disagree	17	3.5
	Missing	40	8.3
Insurance Status	Strongly agree	149	30.8
	Agree	140	29
	Neutral	121	25.1
	Disagree	20	4.1
	Strongly disagree	25	5.2
	Missing	28	5.8
Employment Challenges	Strongly agree	120	24.8
	Agree	137	28.4
	Neutral	152	31.5
	Disagree	20	4.1
	Strongly disagree	23	4.8
	Missing	31	6.4
Child Care	Strongly agree	120	24.8
	Agree	132	27.3
	Neutral	150	31.1
	Disagree	23	4.8
	Strongly disagree	25	5.2
	Missing	33	6.8
Awareness of Available Services	Strongly agree	121	25.1
	Agree	139	28.8

	Neutral	144	29.8
	Disagree	18	3.7
	Strongly disagree	24	5
	Missing	37	7.7
Mistrust of Program and Services	Strongly agree	80	16.6
	Agree	118	24.4
	Neutral	190	39.3
	Disagree	35	7.2
	Strongly disagree	26	5.4
	Missing	34	7
Understanding the words and concepts doctor uses	Strongly agree	77	15.9
	Agree	107	22.2
	Neutral	195	40.4
	Disagree	40	8.3
	Strongly disagree	26	5.4
	Missing	38	7.9
Access to printed materials and doctor's instructions in person's language; availability of interpreter	Strongly agree	78	16.1
	Agree	93	19.3
	Neutral	200	41.4
	Disagree	48	9.9
	Strongly disagree	34	7
	Missing	30	6.2
Support of culture's practices and beliefs	Strongly agree	74	15.3
	Agree	84	17.4
	Neutral	215	44.5
	Disagree	44	9.1
	Strongly disagree	32	6.6
	Missing	34	7
Cost of obtaining prescriptions	Strongly agree	142	29.4
	Agree	130	26.9
	Neutral	145	30
	Disagree	15	3.1
	Strongly disagree	23	4.8
	Missing	28	5.8

Table 34. Race and Health Care

		#	%
Within the last 12 months, when seeking health care, do you feel your experiences were worse than, the same as, or better than for people of other	Worse than other groups	29	6

races, ethnicities or religions?			
	Same as other groups	327	67.7
	Better than other groups	114	23.6
	Missing	13	2.7
Within the past 30 days have you felt upset (physically or emotionally), as a result of how you were treated based on your race?	Yes	55	11.4
	No	395	81.8
	Don't Know/Not sure	21	4.3
	Missing	12	2.5
Do you feel that your race is represented among the community organizations that exist in the county?	Yes	265	54.9
	No	142	29.4
	Don't Know/Not sure	60	12.4
	Missing	16	3.3
Would having more health care providers of your race make you feel more comfortable sharing information?	Yes	107	22.2
	No	251	52
	Don't' Know/Not sure	98	20.3
	Missing	27	5.6

Table 35. Incarceration and Reentry

		#	%
Have you or anyone in your household been incarcerated or arrested in the past 7 years?	Yes	43	9
	No	431	89.2
	Missing	9	1.9
Will someone be returning home from prison to your household in the next 5 years?	Yes	8	1.7
	No	465	96.3
	Missing	10	2.1
Has an arrest record or felony prevented you from gainful employment?	Yes	20	4.1
	No	450	93.2
	Missing	13	2.7
Has an arrest record or felony prevented you from obtaining other basic necessities? (housing, training)	Yes	11	2.3
	No	460	95.2
	Missing	12	2.5
Are you aware of any services available to help you are a loved one reenter the community in an effective way?	Yes	37	7.7
	No	420	87
	Missing	25	5.2

APPENDIX 2. STRUCTURED INTERVIEW COMPLETE DATA

Table 36: Structured interview complete data	
Participants In Health Related Or Social Programs	
Everyone	25% (5)
Younger Residents	10% (2)
Older Residents	30% (6)
Families	30% (6)
Married Residents	15% (3)
Single Residents	5% (1)
Female Residents	45% (9)
A Particular Race/Ethnic Group	5% (1)
LGBTQ Residents	5% (1)
Organization's Target Population	
Everyone	50% (10)
Younger Residents	20% (4)
Older Residents	20% (4)
Families	30% (6)
Married Residents	10% (2)
Single Residents	10% (2)
Female Residents	20% (4)
Male Residents	15% (3)
A Particular Race/Ethnic Group	15% (3)
LGBTQ Residents	5% (1)
Organization's Desired Target Population	
Everyone	75% (15)
Older Residents	5% (1)
Families	10% (2)
A Particular Race/Ethnic Group	10% (2)
LGBTQ Residents	5% (1)
Breakdown of Organization's Members' Race/Ethnicity	
White	
Less Than 10%	15% (3)
10-25%	10% (2)
50-75%	25% (5)
75-100%	25% (5)
Black Or African American	
Less Than 10%	30% (6)
10-25%	10% (2)
25-50%	15% (3)
50-75%	10% (2)
75-100%	10% (2)
Hispanic/Latino	
Less Than 10%	20% (4)
10-25%	30% (6)
25-50%	10% (2)
75-100%	5% (1)
Asian	
Less Than 10%	45% (9)
10-25%	5% (1)
25-50%	5% (1)
Native Hawaiian Or Other Pacific Islander	
Less Than 10%	55% (11)
American Indian, Alaska Native	
Less Than 10%	55% (11)
Other	
Less Than 10%	15% (3)
10-25%	5% (1)

Table 37: Health Of Frederick County Residents	% (n)
Health of FC Residents Is Worse Than Other Counties	
Strongly Agree	15% (3)
Neutral	40% (8)
Disagree	45% (9)
Available Services Are Adequate To Meet The Needs of The County	
Agree	30% (6)
Neutral	10% (2)
Disagree	60% (12)
Programs Adequately Address The Health Issues That County Is Concerned About	
Strongly Agree	5% (1)
Agree	30% (6)
Neutral	35% (7)
Disagree	30% (6)
FC Residents Have Adequate Access To The Needed Programs	
Strongly Agree	5% (1)
Agree	40% (8)
Neutral	30% (6)
Disagree	25% (5)
FC Residents Have unique Health Problems	
Neutral	25% (5)
Disagree	70% (14)
Strongly Agree	5% (1)
Health Priorities of Frederick county Residents	
Weight (Overweight/Obesity)	
Strongly Agree	25% (5)
Agree	60% (12)
Neutral	15% (3)
Physical Activity	
Strongly Agree	10% (2)
Agree	70% (14)
Neutral	15% (3)
Disagree	5% (1)
Cardiovascular Disease	
Strongly Agree	35% (7)
Agree	60% (12)
Disagree	5% (1)
Eating properly	
Strongly Agree	15% (3)
Agree	60% (12)
Neutral	25% (5)
Sexual And Reproductive Health	
Strongly Agree	5% (1)
Agree	45% (9)
Neutral	35% (7)
Disagree	10% (2)
Mental Health	
Strongly Agree	45% (9)
Agree	25% (5)
Neutral	10% (2)
Disagree	20% (4)
Drug Use/Abuse	
Strongly Agree	50% (10)
Agree	30% (6)
Neutral	5% (1)
Disagree	15% (3)
Oral Health	
Strongly Agree	25% (5)

Agree	45% (9)
Neutral	20% (4)
Disagree	5% (1)
Strongly Disagree	5% (1)
Cancer Prevention/Treatment	
Strongly Agree	20% (4)
Agree	65% (13)
Neutral	15% (3)
Sexually Transmitted Infections	
Agree	50% (10)
Neutral	30% (6)
Disagree	20% (4)
Injuries	
Agree	60% (12)
Neutral	40% (8)
Smoking Cessation	
Strongly Agree	15% (3)
Agree	65% (13)
Neutral	15% (3)
Disagree	5% (1)
Asthma/Respiratory Problems	
Strongly Agree	30% (6)
Agree	50% (10)
Neutral	15% (3)
Disagree	5% (1)
Barriers In Receiving Health Care	
Transportation	
Strongly Agree	40% (8)
Agree	50% (10)
Neutral	5% (1)
Disagree	5% (1)
Insurance Problems	
Strongly Agree	35% (7)
Agree	50% (10)
Neutral	10% (2)
Disagree	5% (1)
Employment Challenges	
Strongly Agree	15% (3)
Agree	55% (11)
Neutral	30% (6)
Affordable Child Care	
Strongly Agree	40% (8)
Agree	25% (5)
Neutral	30% (6)
Disagree	5% (1)
Awareness of Available Services	
Strongly Agree	45% (9)
Agree	45% (9)
Disagree	10% (2)
Mistrust of Programs	
Strongly Agree	15% (3)
Agree	30% (6)
Neutral	25% (5)
Disagree	25% (5)
Strongly disagree	5% (1)
Finding Services Where There Is A Way To Communicate in Other Languages	
Strongly Agree	20% (4)
Agree	50% (10)
Neutral	15% (3)

Disagree	10% (2)
Strongly Disagree	5% (1)
Access to Printed Material And Doctor's Instructions In Other Languages	
Strongly Agree	20% (4)
Agree	45% (9)
Neutral	30% (6)
Disagree	5% (1)
Cost/Paying the Co-pays Or Up Front Fees	
Strongly Agree	30% (6)
Agree	55% (11)
Neutral	10% (2)
Disagree	5% (1)
Understanding Words And Concepts That Doctor Uses	
Strongly Agree	20% (4)
Agree	30% (6)
Neutral	40% (8)
Disagree	10% (2)
Doctors Who Do Not Accept Community Member's Health Insurance	
Strongly Agree	35% (7)
Agree	55% (11)
Neutral	10% (2)
Not Enough Time With The Doctor	
Strongly Agree	25% (5)
Agree	50% (10)
Neutral	20% (4)
Disagree	5% (1)
Locating The Right Doctor For The Health Problem	
Strongly Agree	5% (1)
Agree	45% (9)
Neutral	35% (7)
Disagree	15% (3)
How Staff or Physicians Treat People	
Agree	25% (5)
Neutral	40% (8)
Disagree	35% (7)
Finding A Doctor That Respects Cultural Or Religious Needs	
Strongly Agree	10% (2)
Agree	40% (8)
Neutral	35% (7)
Disagree	15% (3)
Cost of Prescriptions	
Strongly Agree	40% (8)
Agree	50% (10)
Neutral	10% (2)
In General, The Health Of The County Is	
Very Good	15% (3)
Good	70% (14)
Fair	10% (2)
Don't Know	5% (1)
In General, The Health of The Community Being Served Is	
Very Good	20% (4)
Good	45% (9)
Fair	15% (3)
Poor	15% (3)
Don't Know	5% (1)
Desired Health Related Programs In The County	
Diabetes/ Cardiovascular Diseases	60% (12)
Cancer	50% (10)
Weight	50% (10)

Physical Activity	55% (11)
Diet	55% (11)
HIV/AIDS	40% (8)
Mental Health	90% (18)
Smoking Cessation	50% (10)
Reentry	45% (9)
Oral Health	80% (12)
LGBTQ Programs	55% (11)

APPENDIX 3. LESSONS LEARNED

SURVEYS

Questions

Future iterations should be more sensitive and culturally appropriate with regard to the manner in which the "speaking" language and similar questions are constructed. These questions were not appropriate for our deaf participants. Additionally, the format of the racial and ethnicity questions could use some reflection based on the difficulty that some of our participants had in self-identifying themselves using the terms provided.

Weather

For future assessments, weather should be considered as a factor in the success of the study. Completing an assessment in the winter outdoor weather was a challenge as it decreased team members' ability to be outside, and it also decreased participant engagement. Winter storms were an obstacle in completing the study on time as there were cancellations and rescheduling of focus groups, and were a factor in low turn-out rates for events where surveys were to be collected. Scheduling assessments in warmer weather has its multiple advantages: more daylight time thereby extending the amount of time both research team and residents can be outdoors, people tend to be out and about more thereby increasing probability of capturing data, there are more community events thereby increasing opportunity to attend events with larger yields of resident attendance.

Retail Locations

Of the eight retail locations that were contacted, only two—Safeway and Walmart—had store policies that allowed store front solicitation. Aldi, Costco, Food Lion, Giant Eagle, K-Mart, and Sam's Club did not allow solicitation. While Safeway and Walmart allowed solicitation, obtaining permission required a lot of follow up and navigation of each store's respective management. Additionally, because these stores allowed solicitors, and because of the season, we had competition scheduling solicitation time for survey collection from The Salvation Army and other holiday solicitors. While survey collection was scheduled for peak times during peak days, these locations only yielded about the average (30 surveys per locations across 16 locations).

Food Banks and Farmer's Markets

While food bank patrons are a great population to capture, unfortunately, the yield of patrons at any of the Frederick County food bank locations was insufficient to prepare and send a research team survey. Through research of food banks peak days varied by location, but peak patrons didn't differ

much—anywhere from 6-10. For future assessments, perhaps considering food banks patrons for focus groups would be a better route. Lastly, reaching food bank organizers proved to be a challenge as there were phone numbers that weren't functioning, emails that didn't yield a reply, and outdated websites providing outdated contact information.

Farmer's Markets can be great locations to survey residents and capture data as they are vendor friendly, yield pedestrian traffic, and also occur in the rural areas of the county (Brunswick, Emmitsburg, Middletown, Thurmont, and Urbana). However, most of these farmer's markets end by November, another reason why temperate weather would be ideal for such a community-oriented assessment.

Faith-based Organizations

Faith-based organizations were a challenge, but definitely worth the effort. Faith-based organizations oftentimes have a nurse or health minister, while navigating any organization's hierarchical arrangement can be time-consuming and require plenty of follow-up, they proved to be assessment advocates and liaised between the research team and pastors/reverends given the team access to survey that particular congregation.

A successful strategy that was implemented at this level included dropping off a certain amount of surveys a week prior to the team's arrival at the site, and promotion of the assessment and team's arrival by the advocate through site communication channels. The day the team arrived, participants who had had a week to fill out the surveys were just dropping off, and participants who wanted to participate but who hadn't had the chance to pick up a survey a week prior, had the opportunity to complete a survey on site. This strategy proved to yield the second highest collection. This strategy was made possible by the great liaison, but also because the congregants are a more closed, constant population rather than a dynamic or transient one which ensured a level of trust that those who took surveys a week prior would bring them back.

FOCUS GROUPS

Because of the remote location of the GWU research team, focus group recruitment responsibility had to be passed onto a community or organization liaison. The successful recruitment of focus group participants required a representative of an organization providing services to residents---liaisons who had access to a community or a population. One person representing a community or population recruiting for participants from that same community or population independent of any organization or affiliation proved to be less fruitful. Recruitment for participants by organization was also a more effective route as space for hosting focus group was readily available and because the

organization served a centralizing entity. For an independent recruiter, securing a hosting location would have been another issue, and issues of accessibility for the group would have been expected.

Guidance from Frederick Memorial Hospital staff as to which communities and populations to aim for to conduct focus group was helpful. A list of community organizations and leaders with access to populations or communities from which the research team can work off of and expand is recommendable for future assessments. Weather, providers, wiggle room, flexibility

INTERVIEWS

The challenges that arose from scheduling interviews had to do with follow-up, receiving replies, and the time between each exchange. Guidance from Frederick Memorial Hospital staff as to who to interview was helpful. An extensive list of community leaders, providers, and any persons of interest is recommendable for future assessments.

ASSESEMENT PROMOTION FOR ACCESS

Frederick County residents seem to be very engaged in the well-being of the county. As such, using the clout and communication channels of Frederick Memorial Hospital and the Department of Health to promote the assessment would be helpful to make pertinent community and county leaders aware of the assessment's goals and need for access to communities, populations, locations, and events. This would be helpful in reaching the rural communities and the non-English speaking populations of the county, given a good standing relationship with FMH and the Department of Health.

On the ground level, the research team found that as time and assessment progressed, more and more community members knew about the assessment through word of mouth and would offer and suggest sites to survey or recruit from. Using channels of communication under the control of FMH and FCDH would mirror such spread of knowledge but in a systematic and organizational manner.

NON-ENGLISH SPEAKING GROUPS

It is recommended to consider the county's different language groups to 1) ensure the capture of their experiences and 2) to best prepare for the linguistic barriers through document translation and interpretation services in all parts of the assessment. Such services add a layer of coordinating and being cognizant of the need to coordinate such services will ensure a pleasant experience for assessment participants, and will communicate that the county is invested in their health.

The End